SOCIAL SECURITY DISABILITY INSURANCE

HEARING

BEFORE THE

SUBCOMMITTEE ON SOCIAL SECURITY

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

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CONTENTS

Page

Press releases Nos. 2 and 3 of June 16 and 23, 1983, announcing hearing 1

WITNESSES

Department of Health and Human Services, Social Security Administration, Paul B. Simmons, Deputy Commissioner for Programs and Policy; Louis B. Hays, Associate Commissioner for Hearings and Appeals, and Acting Deputy to the Deputy Commissioner; Patricia M. Owens, Acting Associate Commissioner for Disability Insurance; ~~and Donald A.~~ Goya, Assistant General Counsel, Social Security Division, Office of the General Counsel, HHS... 28

U.S. General Accounting Office, Peter J. McGough, Associate Director, Human Resources Division, Barry Tice, and Dr. Beryce MacLennan 117

American Association of Psychiatric Services for Children, Karen Litz 159

American Bar Association, Commission on Legal Problems of the Elderly, Daniel Skoler 223

American Mental Health Counsellors Association, Karen Litz............ 159

American Psychiatric Association, Arthur T. Meyerson, M.D............ 149

American Psychological Association, Karen Litz 159

Bartels, Elmer C., Massachusetts Rehabilitation Commission, and Council of State Administrators of Vocational Rehabilitation............ 137

Boggs, Elizabeth M., Consortium for Citizens With Developmental Disabilities, Task Force on Social Security 168

Cohen, Hon. Wilbur J., Save Our Security Coalition............ 89

Consortium for Citizens With Developmental Disabilities, Task Force on Social Security, Elizabeth M. Boggs 168

Cotman, Ivan, Save Our Security Coalition............ 89

Council of State Administrators of Vocational Rehabilitation, Elmer C. Bartels............ 137

Davis, Floyd A., M.D., National Multiple Sclerosis Society............ 229

Downey, Hon. Thomas J., a Representative in Congress from the State of New York 21

Driver, William J., Save Our Security Coalition 89

Fanning, Jeannette L., National Association of Disability Examiners 181

Fried, Bruce M., National Senior Citizens Law Center............ 197

International Association of Psycho-Social Rehabilitation Services, Karen Litz. 159

Jenkins, Hon. Ed, a Representative in Congress from the State of Georgia........ 17

Koyanagi, Chris, National Mental Health Association 159

Levetan, Liane, Commissioner, De Kalb County, Ga., on behalf of National Association of Counties 132

Litz, Karen, on behalf of American Association of Psychiatric Services for Children, American Mental Health Counsellors Association, American Psychological Association, International Association of Psycho-Social Rehabilitation Services, National Alliance for the Mentally Ill, National Association of Social Workers, National Association of State Mental Health Program Directors, National Council of Community Mental Health Centers, and National Mental Health Association............ 159

Manes, Joseph, Mental Health Law Project............ 213

Marshall, Marty, National Association of Disability Examiners 181

Massachusetts Rehabilitation Commission, Elmer C. Bartels............ 137

Mental Health Law Project, Joseph Manes............ 213

Meyerson, Arthur T., M.D., American Psychiatric Association............ 149

National Alliance for the Mentally Ill, Karen Litz............ 159

Page
National Association of Counties, Liane Levetan 182
National Association of Disability Examiners, Jeannette L. Fanning and Marty Marshall 181
National Association of Social Workers, Karen Litz 159
National Association of State Mental Health Program Directors, Karen Litz 159
National Council of Community Mental Health Centers, Karen Litz 159
National Mental Health Association, Karen Litz and Chris Koyanagi 159
National Multiple Sclerosis Society, Floyd A. Davis, M.D 229
National Senior Citizens Law Center, Bruce M. Fried 197
Pepper, Hon. Claude, a Representative in Congress from the State of Florida 5
Save Our Security Coalition, Hon. Wilbur J. Cohen, William J. Driver, and Ivan Cotman 89
Skoler, Daniel, Commission on Legal Problems of the Elderly, American Bar Association 223
Swift, Hon. Al, a Representative in Congress from the State of Washington 24

SUBMISSION FOR THE RECORD

American Cancer Society, statement 24
National Council of SSA Field Operations Locals, AFGE, John D. Harris, statement 236

SOCIAL SECURITY DISABILITY INSURANCE

THURSDAY, JUNE 30, 1983

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON SOCIAL SECURITY,
Washington, D.C.

The subcommittee met at 9 a.m., pursuant to notice, in room B-318, Rayburn House Office Building, Hon. J. J. Pickle (chairman of the subcommittee) presiding.

[The press releases announcing hearing follow:]

[Press Release No. 2, Thursday, June 16, 1983]

HON. J. J. PICKLE, (D-TEXAS), CHAIRMAN, SUBCOMMITTEE ON SOCIAL SECURITY OF THE COMMITTEE ON WAYS AND MEANS, ANNOUNCES A HEARING ON THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAM

The Honorable J. J. Pickle (D-Texas), Chairman of the Subcommittee on Social Security of the Committee on Ways and Means, U. S. House of Representatives, announced today that the Subcommittee will hold a hearing on the social security disability insurance program, focusing on the current adjudicative process both for new claims and for continuation of benefits. The hearing will be held on Wednesday, June 29, 1983, in room 1100 of the Longworth House Office Building, beginning at 9:00 a.m. Testimony will be taken from representatives of the Administration and from interested public witnesses.

This hearing represents a continuation of the subcommittee's work on the disability program and will center on needed improvements in the disability adjudicative process. The Subcommittee is concerned about the direction the current continuing disability investigation (CDI) initiative has taken over the last year. The Administration has taken certain steps during this period to improve the procedures for reexamining beneficiaries, culminating in the administrative initiatives and legislative requests announced by the Secretary of the Department of Health and Human Service, Margaret M. Heckler, on June 7. However, these initiatives fall short of the substantive reform of the determination process that may be required, and which can only be accomplished through legislation. Therefore, the Subcommittee's hearing will be devoted to a detailed examination of the following issues:

The appropriate standards for determining disability both for current beneficiaries and new applicants, including the general issue of medical improvement, and the standard for reviewing beneficiaries who have been on the disability rolls for some time, the medical/vocational criteria for review of mental impairments, and the question of a moratorium on CDI's for mental impairment cases.

The adequacy of current procedures for establishing Federal disability policy for the various levels of the adjudicative process, including how policies are developed and communicated to agency decisionmakers, and the relationship between administrative law judges and the agency,

Possible improvements in the appeal process prior to the ALJ hearing, including continued payment of benefits through a face-to-face hearing as suggested by the Administration, or through the ALJ level, as provided on a temporary basis in P.L. 97-455, and changes in the reconsideration level of appeal.

The current policy of the Social Security Administration of non-acquiescence in decisions by Federal district and appeals courts that overturn agency policies in a way the agency disagrees with.

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD

Individuals and organizations interested in presenting oral testimony before the Subcommittee must submit their requests to be heard by telephone to Harriett Lawler [telephone (202) 225-3627] by noon, Friday, June 24, 1983. The request should be followed by a formal written request addressed to John J. Salmon, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, room 1102 Longworth House Office Building, Washington, D.C. 20515. Notification to those scheduled to appear will be made by telephone as soon as possible after the filing deadline.

In order to assure the most productive use of the limited amount of time available to question hearing witnesses, withnesses scheduled to appear before the subcommittee are required to submit 100 copies of their prepared statements to the full Committee office, room 1102 Longworth House Office Building, at least 24 hours in advance of their scheduled appearances.

Each statement to be presented to the Subcommittee or any written statement submitted for the record must contain the following information:

1. The name, full address, and capacity in which the witness will appear (as well as a telephone number where he or his designated representative may be reached);
2. A list of any clients or persons, or any organization for whom the witness appears; and
3. *A topical outline or summary of comments and recommendations in the full statement.*

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE

Persons submitting a written statement in lieu of a personal appearance should submit at least six (6) copies of their statement by the close of business Friday, July 8, 1983, to John J. Salmon, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C. 20515. If those filing written statements for the record of the printed hearing wish to have their statements distributed to the press and the interested public, they may submit 75 additional copies for this purpose if provided to the Subcommittee during the course of the public hearing.

[Press Release No. 3, Thursday, June 23, 1983]

HON. J. J. PICKLE, (D-TEXAS), CHAIRMAN, SUBCOMMITTEE ON SOCIAL SECURITY OF THE COMMITTEE ON WAYS AND MEANS, ANNOUNCES A CHANGE IN DATE AND LOCATION OF SOCIAL SECURITY DISABILITY INSURANCE HEARINGS

The Honorable J. J. Pickle, (D-Texas), Chairman, Subcommittee on Social Security of the Committee on Ways and Means, U.S. House of Representatives, announced today that the date and location of the Subcommittee's hearing on the social security disability insurance program has been changed from that previously announced in press release #2. The hearing will be held on Thursday, June 30, 1983, in room B-318 of the Rayburn House Office Building, at 9:00 a.m.

As previously announced, requests to be heard must be telephoned to Harriett Lawler [telephone (202) 225-3627] by noon, Friday, June 24, 1983. One hundred copies of prepared statements must be submitted to the full Committee office, room 1102 Longworth House Office Building, at least 24 hours in advance of their scheduled appearances.

Chairman **PICKLE**. The subcommittee will come to order.

We will proceed. The Chairman would like to make an opening statement and then we will go immediately to hear the witnesses.

The first witness will be our distinguished colleague, Senator Pepper.

This hearing marks a continuation in the longstanding commitment of this committee to insure that the social security disability program is run in a manner which is equitable to all claimants and which is also in line with the specific and limited objectives of the program as laid out in the law.

That is a tall order to fill, both for the Congress and for the Social Security Administration, and nothing has made that fact more clear than the progress of this program over the last decade.

The number of disabled workers on the rolls doubled between 1969 and 1977, but the number of disabled workers on the rolls compared to the total number of insured workers is now the lowest in the history of the program.

In the mid-1970's, several factors contributed to variations among States and to an overall lack of coordination and management of the program. Now the States have come to us with complaints that they do not have sufficient latitude to make decisions which they feel are in line with the law and the scope of the program.

Congress enacted amendments in 1980 which increased work incentives for beneficiaries and which gave the Social Security Administration the opportunity for more effective control of the program.

Unfortunately, a hasty and harsh implementation of one provision of the 1980 amendments, that calling for a review of disabled beneficiaries at least once every 3 years, has magnified problems in the program a thousandfold and caused much pain for beneficiaries and much dislocation among agency personnel.

This committee expressed strong and appropriate concern over the apparently uncontrolled growth of the program in the 1970's. However, when it reported the 1980 amendments, the fifth year savings estimate for the 3-year review was $168 million. The fifth year savings assumed in the latest budget, I am told, is somewhere around $1.6 billion.

To the credit of the administration, they have moved on several occasions to address directly the most egregious of the problems in this review. But it is clear to me that the Congress must also take some actions and that those actions must have a definite purpose in mind.

We do have in place tools to have a better control over this program, although there will always be the need for further modifications as we gain more experience and as new problems arise.

The Congress must now take a more affirmative role in setting the overall policy of the program. It is not enough to tell the agency that we do not like something that they are doing.

For this reason, I have reservations about moratoriums, since moratoriums themselves do not solve our problems. We must take the responsibility of telling the agency precisely what policy we want them to follow and to a large degree we must tell them how we expect them to achieve our objectives.

In plain English, I think the task before this committee now is to settle upon and establish a procedure of decisionmaking which will protect both the beneficiary and the program from criticism from either side of the coin.

The program must be well controlled and well run, but that also means it must be neither too strict nor too loose. The only way I know to achieve that goal is to have a procedure which assures uniformity, which is as immune as possible from outside pressures and informal directives, and in which the claimant can feel he or she has been fairly and adequately dealt with.

To that end, we have been holding extensive conversations and discussions with representatives of the claimants groups and the administration. It is the hope of the Chair to draft legislation and—the schedule of the full committee permitting—move it out of the committee and through the House before the August recess.

In these hearings today, we hope to gain greater insight into many of the suggestions which have been made to the committee and to gather general information which will enlighten us as we move forward in the coming weeks.

Mr. Gradison, would you want to make a statement?

Mr. **Gradison**. Yes, Mr. Chairman.

First, I want to concur in your opening remarks, and add just this: The concerns which the Congress has expressed about the administration of this program span a number of years.

The legislation which started this intensive speeded-up review process was passed in 1980 under a different administration, of a different party, and with control of both Houses by the Democratic Party.

We now have a Republican President and one House controlled by Republicans, and one by Democrats. We have many of the same problems.

I bring this up, Mr. Chairman, to indicate that I think we have an issue before us which is a long-term one. It gets to the question of what the definition of disability should be and how these programs should be administered.

I hope that we can approach these hearings in a reasonably objective fashion to try to come up with what the proper answers should be.

Much of the emphasis in recent months has been on, and properly so, the question of whether the administration was too tight, too harsh, unreasonable. I certainly have seen many examples of that in my own constituency.

At the same time, I want to remind the members of the committee how we got where we are; 1980 wasn't that long ago. When those amendments were passed, there was much conversation among members, both on and off the record, about instances which many of us knew about personally of people who were receiving disability benefits and not only were not disabled but were working.

So there is a question of trying to strike a proper balance and of recognizing that for every abuse—and I have no doubt there are abuses which may result from harsh enforcement of the present laws—there may also be instances where taxpayer dollars are going to folks who are not supposed to receive benefits under the program as the Congress has written it.

So, I think our objective should be, for these millions of beneficiaries to come up with an answer that will be fair, that will give benefits to those entitled and deny benefits to those not entitled to them.

And it is a matter, as I see it, of trying to steer down the middle and not go too far one way or the other. Thank you, Mr. Chairman.

Chairman **Pickle**. Thank you, Mr. Gradison.

Our first witness this morning is one of the most remarkable men in America. In earlier times we would say, he is the noblest Roman of them all. He is certainly one of the most distinguished men in public life in America today.

It is my personal privilege to welcome the distinguished gentleman from Florida, Mr. Pepper, to make whatever statement he wishes.

STATEMENT OF HON. CLAUDE PEPPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. PEPPER. Mr. Chairman, members of the committee, I thank you very much for your kind words. My friend knows I esteem him, and appreciate his friendship.

I am very happy to be here this morning, because your subcommittee is dealing with, I believe, one of the most critical questions in human need that is facing the Congress today.

And I am gratified, Mr. Chairman, to hear you say it is your intention to introduce and try to get through the Congress legislation making some needed corrections in the present situation with respect to disability insurance before the August recess.

I certainly will cooperate with you in every way I possibly can to achieve that.

Mr. Chairman, may I commend to your subcommittee a thorough reexamination of the definition of total disability contained in the Social Security Act.

As you know, under that definition:

> A person shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work, but cannot, considering his age, education and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives or whether a specific job agency exists for him, or whether he would be hired if he applied for work.

Mr. Chairman, and members of the committee, that is a definition so strict that I think it is cruel in its application. That would be a typical task to be met by the ablest of men, let us say.

We are dealing with people who have been adjudicated by a competent State agency to be totally incapacitated. And you go tell a man lying on his back in Miami, Fla., well, you are not going to get your disability insurance because we can assure you that some of the technical people, or some Government statistics, or some Government information tells us there is a job you can do in Portland, Oreg.

Here is a man that has been adjudicated totally disabled by a competent State agency, authorized by law to make that determination. He has a family in all probability. If he has not, who is going to look after him, who is going to help him to move in the first place—all expenses of moving.

Then he may go out to Portland, Oreg., and find the job is not available. I just think that is cruelty, to apply that kind of a rigid standard. Very recently the Supreme Court affirmed a decision to deny a person continued payments even though her impairment rendered her incapable of performing her job. The Social Security Administration claimed that somewhere in the national economy there existed a job for her, although they declined to specify just what that job would be or what it would entail.

Mr. Chairman, I know you are a humane man, and so are the members of you committee. I urge you to reexamine that and enact a realistic, reasonable, fair definition of what is disability, and which would entitle her and persons like her to continuation of their payments.

I think that is a grossly unfair criteria for crippled people to have to meet.

Now, we all know, Mr. Chairman, and members of the committee, that at the end of 1978, we had almost 4.9 million beneficiaries who were receiving disability insurance benefits. The number rose through the 1970's to reach a maximum of 4,868,576.

Now, that is when the Carter administration—and it is not one of the things for which the former President will be favorably remembered—began to tighten the administration of the program with respect to people who were applying to receive disability insurance.

As a result, the number of people on the rolls stopped growing and actually started going down. At the end of 1980, the last year of the Carter administration, the number of beneficiaries was 4,682,000. Then came the new administration. And of course, the number of beneficiaries was going—I must say, by the record of this administration, exactly in the direction in which the administration wanted it to go.

But they doubled the rate of decline. You recall that in 1980, the last year of the Carter administration, the number of beneficiaries was 4,682,000. The first year of the Reagan administration, the number went down by more than 225,000 to 4,456,000. The rate at which the rolls were reduced doubled in 1981. In 1982, the next year of the Reagan administration, the rate of reduction doubled again, and the number of people on the rolls dropped to 3,973,000. In the first 3 months of 1983, the number dropped to 3,971,000.

This is a direct result of this administration's efforts to purge the disability rolls. In looking at their disability reviews alone, I believe some 350,000 people have been taken off the rolls. No relief for these people removed from the rolls was in sight until your committee—and I commend you for it, Mr. Chairman, and members of the committee—adopted the temporary extension of the authority to continue the benefits of these people until they are adjudicated to be not disabled by an administrative law judge. Before the adoption of this provision, which I urge you to make permanent, what you did last year, the administration was continuing to dramatically reduce the number of people who were the beneficiaries of this program.

In fact, as you know, this administration in 1981 requested that the Congress approve their initiatives to reduce by a third the total cost of the program. Well, now, Mr. Chairman, you might just as well say you are going to take any other arbitrary figure, in any other arbitrary situation and apply it.

Why a third? Why not less than a third, why not two-thirds? They just took a budgetary objective, a budgetary aim. They wanted to save the money that would be saved if they reduced the beneficiaries by a third.

That, I think, is exactly what happened.

Well, as you know, Congress rejected those initiatives, so the administration began paring the rolls through its review program. As a result, almost every Member of Congress had cases brought to his or her attention from his or her district pointing out tragic cases of where people had been taken off of the rolls, sometimes without a medical examination, and had been lying helpless, and a few of them have taken their own lives because they were helpless and unable to survive, to make a living for themselves.

Well, public opinion came back from the country in revolt against this policy. Your distinguished committee recognized that and you enacted the temporary relief now being enjoyed permitting these people to continue to derive their benefits once they have been adjudged totally disabled until an administrative law judge has determined whether or not their appeal is well-founded.

And now I understand that about 70 percent of the appeals are being regarded favorably by the courts. In other words, the vast majority are successful in those appellate court cases.

Now, then, just let me look at another aspect of it, Mr. Chairman. I am talking about, first, reduction in the number of beneficiaries. Now, let me commend to this subcommittee's attention the reduction in the number of people becoming adjudicated disabled in recent years.

In 1971, the number of new awards per year was 901,000. The next year, it was 991,000. It went up in 1973 to 1,033,000, in 1974 to 1,111,000, and in 1975 to 1,256,000. During the next 3 years the number of new benefit awards stabilized. It went down slightly in 1976 to 1,210,000, and went up slightly the next year to 1,239,000.

After the tightening of the administration of the program under President Carter, it dropped off very distinctly in 1978 to 1,045,000. The number of new benefit awards continued to drop during the last 2 years of the Carter administration, when it dropped from 921,000 new awards in 1979 to 883,000 new awards in 1980. Certainly, it would be difficult for the Reagan administation to claim it inherited a program out of control.

However, when the new administration came in, the same policy was carried out ever more zealously with respect to new applicants.

In 1980, the last year of the Carter administration, the number of new awards was 883,000. The first year of this administration, the number of new awards dropped to 787,000. And then in 1982, it dropped to 641,000.

So we notice a steady decline, then a sharp decline, not only in the new benefit awards, but also in the total number of people that were receiving the benefits who previously had been adjudicated eligible to receive them.

I don't believe the physical facts of the people involved justify those figures. It is the low number of people accepted into the system, and the high number of people removed from the system once they are adjudicated to be a part of it.

Apparently the administration took advantage of the congressional requirement adopted in 1980 requiring a periodic reexamination of the number of people on this roll.

I don't think Congress intended it to be a wholesale wiping out of people already adjudicated to be eligible for it by appropriate State authority, resulting in savings of billions of dollars. Rather, the report to accompany H.R. 3236, the 1980 Disability Insurance Amendments, anticipated a saving of only $10 million.

Now, that didn't mean any widespread reaping of the rolls. In certain instances, of course, there may be cases where people have recovered and they should be removed, of course.

But the Congress didn't contemplate a wholesale slaughter of the people who were already adjudicated and properly on the rolls.

As it has happened—the result of the Congress giving authority to the administration for periodic review, they have now removed something like 350,000 disabled workers and dependents from the rolls. As I said, 70 percent of these cases of removal have been reversed by the law judges, the appellate judges that have jurisdiction over this matter.

The administration initiative, in my opinion, Mr. Chairman, and members of the committee, contains four critical flaws.

First, the caseload is beyond the capacity of State agencies to handle. I could elaborate on that, but you know as well as I do what that situation is. I think we should provide some aid to the States in meeting the heavy load that they have to bear.

Second, guidelines set by the administration which are binding on the initial stages of determination are stricter than those that are binding at the appeals stage, namely, Federal regulations and the law itself. They have applied rules and regulations too stringent and not authorized by the law.

In this regard, you may remember one of the questions in controversy some time ago, and I hope we will have your favorable consideration, Mr. Chairman, is that we do not allow the administration to bind the appeals judges to administrative criteria. Let the law judges continue to act according to the law and to regulations duly promulgated, that is regulations promulgated and published in the Federal Register. Not just an administrative edict handed down by some agency with jurisdiction.

Third, the termination of benefits merely shifts the costs of supporting a disabled person from the social security trust fund, where benefits are paid as a matter of right, to State and local governments where support is uncertain at best.

What are you going to do with a person that cannot meet the technical requirements of social security's guidelines, even if they are stricter than the law. While the Federal Government might save money by removing a disabled person from the rolls, it will cost someone to provide support for him or his family. Who is going to help that person? Obviously, it is going to have to be local welfare agencies.

Fourth, a successful appeal to an administrative law judge takes an average of about 325 days. For most beneficiaries this means 8 to 9 months with no source of income.

To the great commendation of your distinguished committee, you changed that last year, and I am asking you here today to make permanent what you provided last year in your temporary arrangement, for persons adjudicated eligible for this program by appropriate State authority. If such a person found to be not disabled appeals that finding, the law should allow that person to continue to receive the benefits provided for until there is an adverse ruling against that individual by an administrative law judge.

Now, I would be willing, insofar as they are able to do so, to require people whose findings are not reversed, whose removal from the rolls is affirmed by the appellate law judge, to pay back whatever they have received if they are able to do it.

I guess we will have to determine whether they are able to do it or not, whether you are going to collect the money.

So what I am suggesting is this, Mr. Chairman: first, examine the law determining what is eligibility for the receipt of this benefit.

Second, continue the temporary arrangement that your committee enunciated and put into effect last year, allowing people to continue to receive these benefits unless their appeals is denied by an Administrative Law Judge, if they are properly removed.

Those are the main things I wanted to say.

I would like, Mr. Chairman, to submit for the record my statement.

Chairman PICKLE. Your entire statement will be included in the record.

[The prepared statement follows:]

STATEMENT OF HON. CLAUDE PEPPER, CHAIRMAN, COMMITTEE ON RULES

Mr. Chairman, I am pleased to appear before your subcommittee on the Disability Insurance Program. About 115,000,000 working Americans are currently contributors to social security. Their payroll tax contributions are made with the intent of building the foundation of economic security in their old age. Unbeknownst to far too many of them, virtually all salaried Americans are building vital protection in the event than a crippling injury or disease strikes down their earning capacity and threatens to shatter their dream at a young age.

Through the Disability Insurance Program, 97,000,000 workers and their dependents are currently insured in the event of disability. In turn for their payroll contributions, the families of these workers are guaranteed that a portion of the breadwinner's wages will be replaced if their earning power is lost through disability. Although the term "social security" means old age or Medicare benefits in the minds of most people, the irreplaceable protection provided by disability Insurance covers a worker for decades before the benefits of old age or hospital insurance protection become available. The Disability Insurance program is thus an integral and vital part of the nation's social insurance system, insuring workers in a mandatory contributory universal pooled-risk plan.

The statutory definition of disability is contained in Section 223(d)(2)(A) of the Social Security Act: "(A person) shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job agency exists for him, or whether he would be hired if he applied for work."

This definition of disability is one of the strictest of any social insurance program in the western world. In short, a worker must be incapable of performing any job (regardless of whether such a job is available or would be offered anywhere in the national economy) because of a physical or mental condition that is expected to last at least 12 months or to end in death. There is no allowance for partial disability, as is the case with the Veterans' Administration disability program.

In short, Mr. Chairman, there is no free ride to the disability rolls.

Some have tried to characterize Disability Insurance as a billion-dollar giveaway or as a welfare program gone out of control. These charges may win votes but they simply don't coincide with the facts.

The reality is that the program is in a period of contraction. This contraction is not a short-term statistical anomaly; rather it reflects a sustained, significant reduction of the number of Disability Insurance beneficiaries on the rolls. Table 1 contains Social Security Administration data showing that just over 3.917 milllion disabled workers, their spouses and children were in current payment status as of March 31, 1983. This number represents a substantial reduction from the 1978 peak of 4.868 million beneficiaries.

TABLE 1.—DISABILITY INSURANCE BENEFICIARIES IN CURRENT-PAYMENT STATUS, 1976–83

	Number of beneficiaries	Net annual change	Percent change
End of calendar year:			
1976	4,623,827	271,627	5.87
1977	4,854,206	230,379	4.74
1978	4,868,576	14,370	0.29
1979	4,777,218	−91,358	−1.91
1980	4,682,172	−95,046	−2.02
1981	4,456,274	−225,898	−5.07
1982	3,973,465	−482,809	−10.88
March 1983	3,917,044		

Source: Social Security Bulletin, June 1983.

The growth in the disability rolls came to a complete halt under the Carter Administration, which tightened up administration of the program. During the last two years of the Carter Administration, the number of people on the rolls actually shrank by two percent (2%) annually. In 1981, this rate more than doubled to five percent, and last year the rolls shrank by almost eleven percent.

I would also bring to the Subcommittee's attention the number of new benefit awards granted each year, shown in Table 2. Only 641,397 new awards were made in 1982, the smallest number of new awards since 1966. During 1966, only 55,000,000 people were insured for disability—just over half the number insured today.

TABLE 2.—NUMBER OF DISABILITY INSURANCE MONTHLY BENEFITS AWARDED TO DISABLED WORKERS AND THEIR SPOUSES AND CHILDREN 1971–81

	Number of new awards
Calendar year:	
1971	901,343
1972	991,570
1973	1,033,565
1974	1,111,928
1975	1,256,006
1976	1,210,732
1977	1,239,445
1978	1,045,507
1979	921,213
1980	883,984
1981	787,328
1982	641,397

Source: Social Security Bulletin, June 1983.

In summary, it would be difficult to characterize the recent trends in the size of the DI program as expansionary. Clearly, Mr. Chairman, this is also more than just a period of retrenchment. Yet, there are many in this administration who would have us believe that the Disability Insurance rolls are bulging with malingerers eager to take extended vacations on an average monthly benefit of $100 a week. It is for this reason, they claim, that the program must be somehow brought under control. To bring the program under control, this Administration used a procedure mandating priodic reviews of the disability rolls passed by Congress three years ago. As a result we are experiencing the most concerted attack on the disabled people of America since the inception of the Disability Insurance program.

Using that Congressional mandate, this Administration unleased a reign of terror on millions of severely and totally disable people, many of whom died as a result. The review process mandated by Congress in the 1980 Amendments has been perverted beyond recognition. Hundreds of thousands of beneficiaries removed from the rolls lost their homes, their possessions and even their lives waiting for an appeal. Appeals judges reversed most of the benefit terminations, but the process is so backlogged that most appeals take months, or even a year. Clearly this was not what

Congress intended. Rather, it is a tragic case study of what happens when Congressional intent to deny a harsh Administration policy initiative goes ignored.

On page 174 of its fiscal year 1982 budget document, the Administration proposed a cut of $3.4 billion in the Disability Insurance program. They planned to achieve this reduction through what they termed "intensified review" and "improved management."

Congress never acted on these proposals legislatively, but the Administration put them into effect anyway, citing the 1980 Amendments calling for continuing investigations of Disability Insurance beneficiaries. Yet, the Committee report to accompany H.R. 3236, the 1980 Disability Insurance Amendments, anticpated savings of only $10 million attributable to the continuing disability investigations. The savings proposed by the Administration were thus savings above and beyond the implementation of the 1980 law.

The result of this Administration's initiative has been nothing less than a wholesale purge of the disability rolls. Some 350,000 disabled workers and dependents have been thrown off the rolls since this Administration began the reviews in March, 1981. Mr. Chairman, this is the most brutal attack on the crippled people of America since the inception of the Disability Insurance program.

Just two years ago, the Administration brought to Congress its proposals to cut the Disability Insurance program by one-third. These proposals were overwhelmingly rejected by the Congress. It is clear that the budgetary savings that the Administration was unable to obtain legislatively would be obtained through the back door—by throwing crippled people off the disability rolls.

Virtually every Member of Congress has been deluged with individual case examples of disable people who have been terminated from the disability rolls. These examples have brought to our attention through reports from state and local agencies, newspaper investigations, and individual pleas for help. Handling of these cases was characterized by inadequate medical evidence in case development, arbitrary overruling of medical evidence, perfunctory review, appeal and review procedures beyond the capacity of mentally disable beneficiaries, and deceptive notification policies. In short, we are witnessing arbitrary terminations and denials of benefits of the grandest scale in the history of the program.

The Administration's initiative contains four critical flaws:

(1) The caseload is beyond the capacity of state agencies to handle. While the number of review has increased nationally by over 300 percent, staffing has only increased by 27 percent. As a result, the quality of these review decisions has suffered, with the obvious consequence of severly crippled people being terminated from the rolls. I would note that even in 1980, with a much smaller caseload, an SSA study concluded that 40 percent of the case files already lacked medical documentation.

(2) Guidelines set by the Administration which are binding on the initial stages of determination are stricter than those that are binding at the appeals stage—namely, Federal regulations and the law itself. According to the Belimon report, mandated by the 1980 amendments, the disparity between these two sets of standards—those set by SSA and those set by the law and Federal regulation—accounted for more reinstatement of benefit terminations by the appeals judges than any other factor.

For example, SSA admits that it will terminate current beneficiaries whose medical condition has not improved. SSA claims that its new, stricter guidelines are proper even though the statutory definition of disability has not changed since 1967 and at least five court cases have struck down this policy. A General Accounting Office report found that 35 percent of those terminated over the last two years were at least as disabled as when they joined the rolls. It should be no surprise that 70 percent of those who appealed won back their benefits.

(3) Termination of benefits merely shifts the cost of supporting a disabled person from the Social Security Trust Funds where benefits are paid as a matter of right, to State and local governments where support is uncertain at best. Several studies, including ones by the State of Michigan and the City of New York, claim that this cost-shifting will cost State and local governments billions of dollars.

(4) A successful appeal to an administrative law judge takes an average of 325 days. For most beneficiaries, this means 8 to 9 months with no source of income.

The Administration's policy is not only contrary to congressional intent; it places the Social Security Administration at odds with nearly every governmental body—executive, legislative and judicial—in the nation. At least five Federal courts have ordered SSA to terminate benefits only after a satisfactory showing of improvement in a beneficiary's medical condition. Recently the ninth circuit court of appeals ordered SSA to reinstate benefits to about 75,000 disabled people in 9 western states.

Other court orders require SSA to pay interim benefits to 14,000 former beneficiaries in serveral midwestern states while their cases are reopended. At least 20 other major lawsuits, including one by SSA's own Association of Administrative Law Judges, are pending.

In addition, State Governors and Disability Determination Agencies, in at least nine states, have ordered the processing of reviews suspended, ordered disability examiners to follow court orders requiring a medical improvement standard instead of SSA's guidelines, ordered developed or issued guidelines to correct "unduly restrictive interpretations of Federal guidelines", and taken other actions to oppose the Administration's guidelines.

For millions of Americans, Mr. Chairman, this program is the court of last resort. Through no fault of their own, disabled workers on the rolls have no capacity to earn a living. They could not provide for themselves or their loved ones without that monthly check. In addition to allowing a disabled worker to maintain his sense of dignity, the Disability Insurance program provides the means to pay the rent and put food on the table. Those benefits are earned and are received by right. Congress simply cannot allow them to be stripped away at the arbitrary whim of a particular adminstration.

We in Congress may differ over the fairest and most efficient means to administer the program. These differences must be addressed and hopefully resolved in legislation which this subcommittee will consider. It is up to Congress to ensure that the commitment of the Federal Government to every contributing worker and especially to those who incure a severe or permanent disability is upheld.

For this reason, I would strongly urge this Subcommittee to make permanent the provision included in Public Law 97–455 which allows terminated beneficiaries to continue to receive benefits until a disposition is rendered on their appeal. Under current law, this provision would no longer apply to those who are terminated after September 30 of this year.

Your Subcommittee's action on this one provision will determine whether or not Congress is serious about ensuring that beneficiaries who are still disabled continue to receive their benefits. Despite any changes in the administrative or adjudicatory process developed by this Subcommittee, it will still be possible for this Administration to deny benefits to disabled beneficiaries for unacceptable lengths of time no matter how disabled they are found to be upon appeal. I would add that there is ample precedent for this approach of paying disability benefits to persons whom an agency has ruled disabled under Title XVI of the Social Security Act.

There is no cost associated with this change except to the extent that disabled people would no longer be terminated from the rolls without benefits. I would support a provision requiring repayment of extended benefits in the event of an adverse decision, in order to discourage frivolus appeals. But if the disability protection bought by a contributing workers payroll taxes is to mean anything, it cannot be arbitrarily and capriciously taken away.

The Disability Insurance program is not an overly generous program. Its entire cost is about one-and-a-half percent of payroll—a mere fraction of the cash benefit programs provided by Social Security. Disability Insurance is not out of control, except to the extent which we in congress have abdicated its control to a cruel and reckless Administration. For almost four million beneficiaries, however, this program is their lifeblood. It could become the sole source of income to any of 97 million contributors and their dependents at any time. Mr. Chairman, and Members of this Subcommittee, more than 100 million of these Americans are looking to your wisdom and compassion as you consider this matter.

I would be pleased to answer any questions you might have.

Chairman PICKLE. On behalf of the entire committee, I want to thank you now. You, individually, and the Committee on Aging, have been very active in showing your concern about the general problem in the disability field.

Your cooperation with our committee is very much appreciated. I assure you we will work with you and your committee.

This committee has a responsibility of forging now some kind of general agreement. I just simply want to say to you first, the points you make are well taken. I want to say to you, I believe there is a general feeling of accord among the administration officials, the disability groups, and the Congress, to try to come up with more workable, humane rules and regulations.

We are trying to handle our problem in a better manner. And I am confident we will do so. We will try—that is one reason we are trying to finish this legislation if we can before the October 1 deadline, when these extra benefits would cease.

So we are under a time constraint. We want to do it. And I believe there is a spirit of cooperation. We will keep in mind the very points you have made and work closely with you.

I thank you for it.

Does any member of the committee want to ask any questions of the Senator? Mr. Archer?

Mr. **Archer**. Mr. Chairman, I just wanted to go over a couple of things. I appreciate your coming and testifying before us, as our colleague and friend from Florida.

I am concerned about one aspect of the contrary forces that seem to be working on the administration.

We are telling them by congressional intent to do a certain thing. Obviously, there is some leeway in the methods by which they implement our congressional intent, and different people can take different positions as to whether they are implementing it in the way we intended for them to do so.

That is one aspect of it. The other aspect is that the congressional budget forces upon them a certain amount of monetary savings in the way that this review is performed. The chairman of the subcommittee mentioned in his short statement that the budget that was just passed by the Congress—this is the congressional budget, not the budget that the President recommended, this is a budget that the President opposed, as a matter of fact—provides that the fifth year savings will be $1.6 billion from this program.

And yet, currently, the method by which the program is being implemented will produce only $168 million in savings. Now, if I were over at the Social Security Administration, and I were told on one hand that this is the intent, what we ought to do, save less money, and then the budget that the Congress passes says you have to save 10 times more than you are already saving, then what do you do?

And I just wonder if you have any suggestions on that? I assume you supported this budget.

Mr. **Pepper**. I did support the budget. But I wasn't aware there was a provision like that in it, I will say to my friend. I don't understand how there could have been that large an anticipation of a savings.

Surely the Democratic budget didn't contemplate that the number of people to be removed from the rolls should be multiplied beyond the number now being removed. I cannot believe that——

Mr. **Archer**. I can't, either. I just wonder how the gentleman would suggest that these savings are going to be accomplished?

Mr. **Pepper**. I haven't seen that item in the budget. But I was just going to say a moment ago——

Chairman **Pickle**. Senator, would you yield to me just a second? Mr. Archer mentioned my statement. I pointed out when the House made its budget in 1980, based on the law we passed, we thought the saving would be around $168 million.

Now, the figures you quoted, saying that the budget this year says $1.6 billion saving, that may or may not be in the House budget.

But that was in President Reagan's base line budget.

Mr. ARCHER. I am told by staff, Mr. Chairman, that is included in the budget that was adopted by the House.

Chairman PICKLE. It was also recommended by the administration. I hope we don't get in the business of saying whether the administration or the Congress made these savings. The savings have been made.

And they are about five times greater than we thought they would be back in 1980 when we passed the bill. I hope we don't try to distort figures now.

Mr. ARCHER. Mr. Chairman, I am not trying to distort them. I am trying to get them on the record so we can fully look at the problems that are going to be presented to any administration, whether it is this administration or the Carter administration or whatever.

If on the one hand we tell them we want you to reform the program, and we want you to review these cases, and on the other hand, we also tell them we expect this amount of savings, and we write that into our congressional budget, then we make a very difficult task for them.

And there is a great inconsistency, when the Congress embraces a budget that assures a certain amount of savings, and then criticizes the administration for trying to accomplish those savings.

Mr. PEPPER. Let me say to my friend—it is totally wrong for us to try to budget, except in the vaguest kind of speculative way, the number of people who are going to improve physically or the number of people who should be removed from the rolls.

It is wrong. You must just as well say that of a certain number of people in a hospital, we are going to assume that 15 percent will recover in some arbitrary time, 25 percent will not require surgery, and mandate that they be treated accordingly. It depends on the facts.

We ought not to try to mandate a removal of a certain number of people from those rolls, because whether they should be removed from the rolls depends upon their physical situation, and a fair, competent evaluation of their physical situation.

It hasn't got anything to do with the budget. So it is a gross error. I don't care who does it. It is a gross error to postulate we are going to remove so many people from those roles without knowing the justified facts.

Mr. ARCHER. I would say to my friend from Florida, that is a problem that I am enunciating, because that is exactly what the budget does.

The budget does assume certain figures in this category.

Mr. PEPPER. It is a mere speculation. Anybody that tries to fit the facts to the budget is doing a grave injustice and perpetuating human misery.

Mr. ARCHER. The Members of Congress, when they go throughout the country and tell the country they have established a certain deficit and they are moving toward a balanced budget, and that their deficit is either larger or smaller than anybody else's deficit, they are including this figure in their comments.

Now, it is unfair, and it is wrong for Members of Congress to say we are reducing the deficit if in fact they do not intend to implement what they have put in this category in the budget.

And if they don't intend to do it, then they should face up to a bigger figure, as you say, and admit to a bigger deficit.

And that is the only point that I am making. But I would also say to the gentleman from Florida that one of the reasons that we got into this in the first place, as he well knows, is that we had numerous complaints from people across this country of individuals who were drawing disability, who were physically able to work.

My files are full of them, where people have written to me and said so-and-so down the street from me is drawing disability and I am paying for that, and he is able to work.

And so, this sort of pressure is what forced us into this. Now, we have to find the balance to protect those people who are truly disabled, but still take care of these massive complaints of people who can work that the Congress has received over the last few years.

Mr. **Pepper**. I believe you have more complaints now about the removal of people than there were about people being improperly on the rolls previously.

Chairman **Pickle**. The Chair would like to make this observation at this point: We have four or five other Members of Congress here to testify. We have a large witness list for the day. We need to get a lot of testimony on the record.

I don't want to cut any Member off. I would make this observation about the issue at hand: I think we all agree that the reason the reviews were instituted, and the reason we are concerned with this program now, is that we are trying to determine who is able to work and who is not able to work.

That is what we are trying to establish. We were not trying to save money. That was not the objective of the Congress. Inadvertently and indirectly, of course, the question of a saving does come about, it has to be computed, it is an issue of budgetary concern, and the gentleman from Texas is right.

And I hope at this point we do not try to point the finger about who caused the harshness or how are the big savings made. We all have our individual thoughts on that. That is not going to help us here today.

I hope we can proceed now with the various testimony of the members and try to get on the record the information we need so that we can get about the business of putting a bill together.

Mr. **Gradison**. Mr. Chairman, I would like to pursue what you just said. I happen to agree with you. I think until we set aside some of the partisan considerations which have been injected into this hearing by the testimony of the gentleman from Florida, we are not going to get to the heart of these issues.

The fact of the matter is that the downturn in the applications for coverage under this program began in 1979.

Mr. **Pepper**. I said that.

Mr. **Gradison**. But you used words, sir, such as slaughter, to indicate your views of the way the program is now being administered. You are entitled to those views. But I am entitled also to say this: Just as we have a responsibility, and we do, to be compassionate to those who are intended to be covered by this program, we have a responsibility to be compassionate to people who pay taxes for this program.

I listened very carefully to your recommendations. I hope you will elaborate upon them if I misunderstood them. But, the only recommendation I heard you make is that you want us to continue the provision, which this committee I think unanimously in a bipartisan manner put into effect, to permit continuation of the payments until the face-to-face hearing.

If you had other recommendations, I did not hear them. And I would appreciate it if you would spell them out.

Mr. **PEPPER**. I recommended you change the definition, that is the first point that I made—change the definition. It is totally inhuman and totally unreal, the definition of disability that is in the law.

Chairman **PICKLE**. Mr. Gradison, the Senator did make that point and several other points. We have his full statement. He is making specific recommendations. To that extent, he is making concrete suggestions for our committee to consider.

Mr. **GRADISON**. Do you have any figures, Senator, in terms of the additional cost of the program if the definition of disability were modified as you are suggesting?

Mr. **PEPPER**. No, I have not. And I am not concerned, to be frank with you. If we are undertaking to help totally disabled people, we will help the number that are totally disabled by a fair definition——

Of course, if there are more people disabled, it will cost more. But I think it is an expense we would all be agreeable to.

Mr. **GRADISON**. In view of the excellent financial condition of the social security program, I am sure we will find a way to accommodate that in this subcommittee with no difficulty at all.

Thank you, Mr. Chairman.

Chairman **PICKLE**. Any other members have any comments or quesions?

Mr. **SHANNON**. Yes, Mr. Chairman.

I just want to thank the chairman of the Rules Committee for testifying. I do want to say that while I hope that we are going to be able to work on this issue on a bipartisan basis, if we can't, I am delighted that our party is going to take the lead to make the necessary reforms in this system.

I can well understand the sensitivity, political sensitivity, of the members of the minority to this issue because of the abysmal record of this administration in dealing with the disability system. And if it takes words like "slaughter" and "political dynamite" to get the Congress moving and to get the administration to change its position, I want to applaud the gentlemen for using those terms.

Mr. **PEPPER**. I thank the gentleman.

Chairman **PICKLE**. I thank you very much.

Any other questions?

Senator Pepper, we thank you. For the record, I know you said—you used the word "slaughter." But your testimony said these disability reviews were a "reign of terror."

Thank you very much, Senator.

Now the Chair is going to ask our colleagues, Ed Jenkins, Tom Downey, and Al Swift to come to the witness table.

While they are taking their seats, we are going to take a temporary pause in order to allow the staff to pass out the various statements.

At this time we will hear statements from Congressman Jenkins, Congressman Downey, and Congressman Swift, and in that order, if that is agreeable to the committee.

We would hope that each of you gentlemen might abide by the 5-minute rule. Your whole statement will be made a part of the record.

Mr. Jenkins?

STATEMENT OF HON. ED JENKINS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. **Jenkins**. Thank you very much, Mr. Chairman.

I do appreciate the opportunity to appear before the subcommittee and to make some recommendations I believe that the disability insurance program is one of the most volatile and serious problems that this subcommittee will face in some time.

I have made various recommendations that are in my entire statement for the record. But I want to elaborate on them and on an issue that Congressman Pepper also alluded to that is not included in my statement this morning.

At the onset, let me say this: As a lawyer, through the years, I have tried social security cases before administrative law judges. I am familiar with the procedure that have been developed through the years, some of the difficulties, and some of the problems that this subcommittee and this Congress face today in trying to improve this program.

Without any question, each of us, and Members of Congress, have seen horror stories and mistakes, that should not have occurred. We will probably see those in the future, because we will not be able to make a perfect program however hard we try.

But I want to offer some specific recommendations that this subcommittee might consider.

Let me first address the matter that Mr. Pepper alluded to, the definition of disability.

His perception and analysis is accurate in so many cases where an occupational expert testifies at an ALJ hearing that a person is unable to work, but that he does have the ability to work in some capacity, Then the occupational expert will give a list of the employment positions that this person could possibly perform.

Time after time I have heard occupational experts testify before the ALJ that this person is unable to lift more than 10 or 15 pounds, that they are uneducated, that they are untrained, but they could work, say, as a parking lot attendant. Well, one problem in this instance is that I don't have a pay parking lot in my mostly rural district. I would estimate that a parking lot is not within 75 miles of where these rural people live. They would have to travel to the city of Atlanta, and try to seek employment at a parking lot in order that they perform that recommended duty.

That is simply unreasonable. I have heard occupational experts testify time and time again that this person is disabled to do most things, but they could perhaps operate an elevator. Well, there are no manually operated elevators within 100 miles of where this person lives.

Now, the real difficulty is that apparently under the law, there is a requirement that this person relocate. This proves to be a real difficult problem. I know there is presently some discretion with the ALJ. But in my opinion, what we must to do in this field is to grant greater discretion to the ALJ's.

I would like to recommend a geographic limit of the home in this regard. But I understand the difficulties this committee will face when you do that, because you will find maybe in the West where you won't have 200 people living in a 40-mile radius. So it is very difficult to narrow it down to a specific geographic limitation.

But I would think the committee ought to consider giving the ALJ greater flexibility, greater discretion, when he makes a determination that the applicant is unable to do the type of work he or she was doing before they became disabled, but still may have some capacity to do something in some far off land.

Mr. Chairman, my second recommendation deals with the disability process itself. I know there are different approaches to the examinations of the disabled, but at some point I feel that the burden of proof ought to shift from the applicant to the Social Security Administration to prove disability rather than to leave that burden upon the applicant.

I agree with the proposition that the applicant ought to have the burden of proof of disability with the initial application. But after a certain period of time, in my view the burden ought to shift; whether it be after 2, 3, or 4 years. At some point that burden should shift to the Social Security Administration to disprove disability.

A problem with the way the law is working today is that so often people are being severed from the rolls of disability by mail—simply by mail. They get a letter. Then there is a reconsideration, followed by a host of other letters. The poor recipient goes to his or her family doctor, who, once again, supplies medical evidence confirming the disabling factors. This medical evidence, however, seems to be totally disregarded until the appeal at the ALJ stage. This disregard causes a great deal of turmoil which is not necessary.

Mr. Chairman, I realize that my time limit has expired. I have several other recommendations in my statement that I have submitted for the record, and I appreciate the opportunity of being here.

[The prepared statement follows:]

STATEMENT OF HON. ED JENKINS A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. Chairman, I deeply appreciate having the opportunity to make a presentation to this distinguished panel this morning, and I commend you and other Members of the Subcommittee for holding this important hearing on the Social Security Disability Insurance program.

It has been reported that "hundreds of horror stories have made their way to Capitol Hill over the past year and a half as the Reagan Administration has tried to comply with a Congressional mandate to prune the Social Security disability rolls of ineligible recipients." My constituents, as well as your own, supplied me with their personal stories in this regard. If I may, I would like to relate just a few examples of the ones I have received:

Constituent: "I am very angry about the torture of filing and waiting for an answer for so long. I feel angry and upset by the discrimination and the dehumanizing, demoralizing manner in which I have been treated by the officials in the Social Security Administration. It seems that the Administrative Law Judge is playing some kind of God, in that he feels he is in a role of power and is more compentent to evaluate my disability than the physicians, myself, or the other witnesses."

Another constituent wrote: "I was granted disability by the Administrative Law Judge but my files were sent to the review board, who then denied this. As of today, the review board has been sent new medical evidence that my condition has worsened and there is no way I can hold down any kind of work. I am a married man with a family of six, and I do desperately need the Social Security before I lose everything I own, which isn't much."

Finally, a constituent wrote: "I have put in for my disability but I cannot get it. I am glad you are far away so maybe I can talk to you. I can't to my doctor or my family at times. The doctor told my husband what was wrong with me. I did not know. I can't (sic) hardly write now, I have tears in my eyes. I cry a lot. I think sometimes my children don't love me or even my husband, who is real good to me. Congressman, I have been 3 days writing this. I am sick and can't understand why. I would like for you to help if you can. I wish I could work and be well like I once was and not go through all this."

Mr. Chairman, these are but three personal testimonies of the disability review process in my own Congressional district. I am confident that similar stories have been related to each and every Member of this Congress. I am familiar with the disability review process, the continuing investigations procedure, and the apparent need for legislative actions which pertain to these procedures. I also understand that a coalition has recommended legislative action to this Subcommittee. Based on the expertise which the Subcommittee has developed, which eliminates the need for a recapitulation of the facts, let me simply offer some suggestions which you may want to consider.

It is my belief that the Social Security Administration is not adequately explaining the disability program to the claimant. In testimony before the Senate Committee on Aging, SSA Deputy Commissioner Paul Simmons said, "there is a public misperception of just what the program is intended to do: provide benfits for the severely disabled who are unable to engage in, not only their previous job, but any other kind of substantial gainful work." Simmons continued, "Now . . . people have been on the (disability) rolls for 10 years and they are disabled in their heads. They never thought their cases would be reviewed. In their own minds, they have 'retired' on disability."

While I do not disagree with the assessment of Deputy Commissioner Simmons in some cases, I find particular fault in the system which does not provide for a "public education" process by the local claims representatives of the Social Security Administration. These officials should be forthright in explaining the the Disability Insurance program is indeed nonpermanent and that periodic reviews are necessary and required by law. The general public, through an ongoing educational process, must understand that the possibility of physical of mental improvement of their particular disability may eliminate their qualifying for continued benefits. They must understand that the program was not originally designed, nor is it intended today, to provide permanent disability benefits for every claimant who is awarded initial benefits. It is incumbent on each of us, as advocates for our constituents, to help explain the program prior to, during, and after the award has been made if it is so granted.

Mr. Chairman, my second recommendation deals with the process itself involving age and vocational factors in determining initial disability applications. Basically, I support two concepts in this regard:

(1) Criteria should be developed to allow for some initial disability claimants to have a face-to-face interview with a Disability Determination Section examiner.—As you know, the Congress recently passed P.L. 97-455 which included a provision for face-to-face reconsiderations. But, my suggestion is to allow for this procedure, in the most severe cases as judged by the initial claims representative, at the beginning rather than at reconsideration. This would eliminate the necessity of delaying approved benefits because of a backlog of cases awaiting adjudication at the State agency.

(2) Vocational, rehabilitation, and retraining factors should receive greater emphasis for claimants who are age 40 and below.—The technology of rehabilitation has certainly expanded during the past few years. Studies have shown that we, as a nation, are more service-industry oriented than ever before. Therefore, job opportunities should continue to rise which de-emphasize physical qualities for the worker. This again relates to my statement for a public education process by the Social Security officials. I understand that it is not the responsibility of the Social Security Administration to ensure that the individual is able to find work. However, it should be incumbent upon the disability adjudicators to consider the relative chances for employment given the medical evidence supporting at least partial disabling conditions. I believe vocational rehabilitation workshops and sheltered workshop programs which, in my own State of Georgia are a part of the State Department of Human Resources, could be better utilized in this regard.

Individuals who have self-imposed disabilities, such as obesity and alcoholism, should be enrolled in an approved rehabilitation program as a condition to receiving disability benefits. Again, vocational factors should be considered.

My third and final recommendation, Mr. Chairman, pertains to the need for Continuing Disability Investigations (CDI). Most of the provisions to modify CDI are included in HR 2987,[1] which was written by our committee colleagues, Mr. Shannon and Mr. Stark. I support the need for continued investigations in a humane and decent manner.

Mr. Chairman, I believe that the burden of proof should be shifted however during the continued disability investigation. Rather than require the claimant prove disability, why not have the Social Security Administration disprove it? The burden fell upon the claimant during the initial process. The burden to disprove initial findings should shift to the Social Security Administration during the CDI. This suggestion should not be construed as a contradiction of my support for the intent of the CDI. Rather, it should dispel the alleged public perception that the SSA is being required to eliminate a certain percentage of beneficiaries by this or any other Administration. Require the Social Security Administration to use advanced medical and vocational data before announcing a termination of payments to the beneficiary.

I also believe that disability beneficiaries, who have been approved for 10 years or longer for non-mental impairments, should receive vocational and psychological testing to determine the feasibility of their successfully re-entering the job market. Again, this relates to advanced technology in both our job opportunities which require less physical output and the advances that have been made in vocational rehabilitation.

Finally, disability guidelines for the Disability Determination Section (DDS) examiner and the Administrative Law Judge (ALJ) should be more compatible. You are certainly aware of the incredible rate, I believe in excess of 60 percent, where DDS decisions have been reversed by an ALJ. More compatible guidelines should lend to a lesser reversal rate by the ALJ's.

Mr. Chairman, in summary, let me simply state that we are trying to seek humane and moral avenues to relieve a complex and difficult program. This program affects the livelihoods and indeed the lives of millions of Americans. I respectfully urge your continued consideration in pursuing disability guidelines which are dynamic yet flexible enough to reach medical technology and research.

I do not condone, and I am unaware of any Member of Congress who condones, the receipt of disability benefits by those who are not deserving. I want the process to be compassionate, fair, and just.

In closing, please allow me to quote from one last constituent letter received just this week: "I hope I can continue to work as I, like thousands of others, no doubt had rather be working than drawing a disability check, if I can continue to. There is a certain stigma that goes along with drawing a disability check that is hard for a man to live with, even though by law and misfortune many people, as in my circumstance, cannot avoid, because I think that any 'man' had rather be working and make, in almost *any* job in the United States, more money than he can drawing a disability check—and, if given the chance, as I finally was, will work for minimum wage or whatever."

Again, I appreciate having the opportunity to be here today. Thank you.

Chairman Pickle. Thank you, Mr. Jenkins. I thank you for your recommendations. I find them interesting.

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[1] A bill to amend the Social Security Act to provide for reform in the disability determination process.

Mr. **Jenkins**. Did you say supportive?

Chairman **Pickle**. I am generally supportive. But I am just wondering what part of the country you live in that won't have an elevator within 100 miles. I imagine it is backwoods Georgia.

Mr. **Jenkins**. Mr. Chairman, you probably have some areas in Texas like that.

Chairman **Pickle**. I thank you. You do have good points.

Now, Mr. Downey.

STATEMENT OF HON. THOMAS J. DOWNEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. **Downey**. Thank you, Mr. Chairman. After listening to the exchange of my good friends, Mr. Gradison and Mr. Shannon, I am not sure I want to testify. But let me say that I feel this problem has to be solved in a bipartisan way or it is not going to be solved at all. And it has got to be solved.

I have a very specific issue to discuss. On May 18, I introduced H.R. 3045, a bill which imposes a complete moratorium on all periodic review continuing disability investigations. This bill would stop the flow of cases from the Social Security Administration to State agencies, and cases already in the pipeline would receive no further consideration. This moratorium would stay in effect until Congress has spelled out in law the guidelines under which it wants the program to be operated.

Over the last year and a half, a number of administrative and legislative initiatives have improved the program. The June 7 announcement from the Secretary of HHS was another welcome sign that even the administration is fully admitting that the review process is "too insensitive; too bureaucratic." And I want to thank the chairman and members of this subcommittee for the active role they have played in achieving these changes.

So why do we need a moratorium at this point? Because although all these efforts have helped, they are not enough.

My office is still inundated with calls for help from constituents who have been terminated from the program. The newspapers still contain daily horror stories of people who have died, lost their homes, had their family life disrupted because they were inappropriately determined to be healthy enough to work.

Federal court rulings are claiming that SSA policies are incorrect and are returning thousands of people back onto the disability rolls. There are at least 20 Federal court cases pending, including a suit filed against SSA by their own employees, the ALJ's.

The States are rebelling against SSA's guidelines. Just last week, nine State Governors and disability determination agency officials testified before the House Aging Committee that they are actively opposed to the SSA's policy and administrative guidelines. My own State of New York has entered into a lawsuit against SSA which challenges the eligibility standards and seeks a change in those standards. Other States such as Massachusetts, have already gone ahead and ordered the State disability examiners to follow court orders which directly conflict with the administration's current policy.

The program also violates the original congressional intent. When we passed this 3-year review mandate in 1980, we expected the program to cost us about $40 million in the first few years of operation. Yet the administration has testified this year that they expect savings of more than $1 billion in the years 1982 through 1984. Clearly, the program isn't being run the way we thought it should in 1980.

And everyone agrees that something is grossly wrong. The fact that we are all sitting here today and that you are once again working on a comprehensive reform package indicates your view. The GAO recently testified before the Senate on the blatant abuses and improper treatment of the mentally ill. I know that Chairman Roybal, of the House Aging Committee, just last Tuesday sent a letter to Secretary Heckler asking that she institute a complete moratorium. Senator Heinz's bill imposing a moratorium on reviews of the mentally disabled easily passed the Senate, indicating that Chamber's dissatisfaction. And volumes of anecdotal evidence and testimony submitted by doctors, lawyers, State officials, ALJ's, and beneficiaries all repeat the same message.

If everyone agrees that the program is inadequate, why are we allowing it to continue?

I am asking for a moratorium because I think it will help answer another extremely difficult question. That is, what are we going to do with the more than a half million disabled people and their dependents who have already been terminated, once a reform bill is passed? Are we going to tell them that we have changed the rules in the middle of the game, but that due to the luck of the draw, their cases will not be reconsidered under the new rules? Of course we can't.

Now with that as a premise, does it make sense to have State and Federal employees go ahead and continue reviewing cases under current procedures when there is a very great chance that we are going to change those procedures in the near future?

I don't pretend that this bill will solve the very serious problems facing the SSDI program, and it is not intended to serve as a backdoor effort to repeal the 1980 amendments. The question of how to objectively define "disability" is one of the most complex tasks the Government ever set for itself. On top of this inherent complexity, this specific issue has become one of the most popular political footballs we have to throw around. And, unfortunately, I think it is going to take a substantial amount of time to find a solution on which we all agree.

The purpose of my bill is very simple. It has the goal of protecting the disabled while we politicians and bureaucrats fight out how to best restructure the program.

Which brings me to my next point. I would like to take this opportunity to outline some of my own concerns about the program, and to highlight some points that I would like to see part of any reform package. I also want to commend my colleague, Mr. Shannon, for the leadership he has demonstrated by his introduction of H.R. 2987. I think this is a very comprehensive, responsive bill which has as its first priority the protection of the disabled. I urge the subcommittee to look at it very closely.

First, it is essential that the current law allowing for continued payment of benefits through the ALJ level be made permanent. The human misery that resulted from abrupt benefit cutoffs prior to passage of the Virgin Islands tax bill cannot be allowed to continue.

Second, I believe that "medical improvement" should be reinstated as a basic requirement for cessation of disability benefits. Unless a current recipient has shown improvement, benefits should not be ceased because current rules are stricter than they were when the recipient was allowed onto the program. It was worth noting that a major Federal court ruling was made last week on this issue. The Ninth Circuit Court of Appeals ordered SSA to reinstate benefits to more than 75,000 disabled people in nine Western States.

Third, it is important that more funding be provided for vocational training and rehabilitation efforts. These efforts should be targeted at helping people get off the program, but also toward helping prepare those who have already been terminated for reentry into the work force.

Fourth, I am convinced that it is time for a total review of current disability and documentational requirements. Although SSA in its June 7 statement promised to do a "top to bottom" study of the program, I suggest that this study be done by a panel of outside experts and that it encompasses both physical and mental disabilities. Use of outside experts would restore public confidence in the fairness of the requirements, and would allow it to be done in a less politically-charged atmosphere.

Before closing, I want to touch on a criticism that has already been made of my bill. The argument has been made that the administrative difficulties associated with the bill are monumental, and that the bill cannot be considered for that reason. I disagree.

First, if we are so concerned about administrative difficulties, why didn't we do more to help the States out over the last 2 years as caseloads tripled while staffing levels were only marginally increased?

Second, I asked New York State officials to tell me how the moratorium would affect their program. They indicated that there would be little or no administrative problem at all for the first 6 to 9 months. In fact, State officials pointed out that numerous benefits would result. For example, the moratorium would allow the State to implement and increase delayed training efforts—New York had originally asked SSA for 6 months to train staff before beginning the periodic reviews. Instead, SSA started the reviews 9 months earlier than specified in the law.

The State could devote more resources to making determinations on initial cases and regular CDI's. The quality of decisions would improve. Further, State officials persuasively argued that if they are allowed to conduct face-to-face reconsiderations, as they would like to, and which are scheduled to start next January, this might be a good time to start training staff for this function.

I am not denying that there would be some administrative difficulty and cost associated with a complete moratorium. But in my mind, the bottom line is that we have to make a choice. We must decide where our first priority lies—with the bureaucrats or with the disabled.

I thank you for the opportunity to testify before the committee this morning.

Chairman PICKLE. We thank you, Mr. Downey. You have given us a very good statement. The question of a moratorium is a very serious one. I personally think it is better for us in the committee to try to find an answer in the new standard required, more than just a moratorium. But it is a problem for us to handle.

Mr. Swift, we would be pleased now to receive your statement.

STATEMENT OF HON. AL SWIFT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mr. SWIFT. Mr. Chairman, members of the committee, thank you very much, especially for permitting me to testify on an issue regarding disability that is slightly tangential to the basic thrust of your hearings, an issue which I think needs to be raised from time to time because, ultimately, it must be dealt with.

I would also ask unanimous consent that the testimony provided to me for you by the American Cancer Society be included in the record.

Chairman PICKLE. Without objection.

[The information follows:]

STATEMENT OF THE AMERICAN CANCER SOCIETY

Imagine being a woman around sixty, a widow. You had spent your life taking care of your family and working as a seamstress. You have one child, a daughter with a young child and a small but adequate income. You are dying of cancer and have been totally disabled for several months. You have no income anymore and collect no pension from your husband's years of work. You have applied for Social Security disability benefits and were told that you had to wait five months to collect your first check. At the end of the five months you contact your Congressman and ask for help. One month after you receive your first and only check, you die. This actually happened. This woman was lucky. Over 50 percent of the people in her position never receive the first check.

The American Cancer Society, the worlds largest voluntary health organization with over two and one half million volunteers strongly supports any efforts to eliminate the five month waiting period for the terminally ill for collection of disability insurance benefits. In addition, we are eager for completion of any government study which might give us additional information relative to the cost of this legislation.

For the past several years, through three Congresses, the American Cancer Society has worked to eliminate what we believe to be an unfair provision of the disability insurance laws. During that time we have repeatedly been told that the cost of eliminating this provision for a five month waiting period would be prohibitive. Yet, our repeated attempts to obtain data or to request that the government undertake to get data have been ignored.

In 1980, when the elimination of the waiting period was passed by the Senate but not by the House and was lost in conference, a study on the cost of this change was mandated by P.L. 96-265. The law stated, "Sec. 506 (a) The Secretary of Health and Human Services is authorized to provide for the participation, by the Social Security Administration in a demonstration project relating to the terminally ill which is currently being conducted within the Department of Health and Human Services. The purpose of such participation shall be to study the impact on the terminally ill of provisions of the disability program administered by the Social Security Administration and to determine how best to provide services needed by persons who are terminally ill through programs over which the Social Security Administration has administrative responsibility. (b) For the purpose of carrying out this section there are authorized to be appropriated such sums (not in excess of $2,000,000 for any fiscal year) as may be necessary".[1]

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[1] 42 USC 139511.

To the best of our knowledge that study has never been carried out, permitting those in the federal government interested in maintaining the present provisions of the law to say that the cost is unknown and probably prohibitive. We strongly urge this Committee, at the very least, to mandate the study and to insist that this time it be actually conducted and results made available to this Committee.

It should be noted, however, that the American Cancer Society position is, and is likely to remain, that whatever the cost, it is the duty of our government under it's contract with our citizens who pay into the Social Security system to pay these benefits. The one statistic we were able to secure from the Social Security Administration over these last years was that the average person who is terminal and disabled will live for only 2.5 months after that diagnosis. It is, therefore, very clear how the government saves money through a five month waiting period. We at the American Cancer Society believe that very few Americans would approve if they understood.

This year 440,000 Americans will die of cancer alone. These deaths are sometimes extremely difficult and usually very costly, not only in the obvious human terms, but also in financial terms.

It costs, on the average, $20,000 to die of cancer in this country. It can cost much more.

For those of our citizens who have paid into the Social Security system all of their working lives, who have contributed to our nation through their labor and who expected to collect retirement benefits, it comes a rude shock at the most trying time to discover that their government has found a way to save money. The government has discovered that if you are dying and you are disabled the chances are that you will only live for a short time. If you have to wait five months to collect your disability the chances are equally high that the government will never have to pay you a dime—an interesting but cruel way to save federal money.

Two out of three American families will have cancer afflict one of their family members. Thirty percent of us will have cancer, 855,000 this year alone. The health care costs of this disease are staggering and the cost in forced liquidation of assets and lost wages comes to between $13.7 and $17.1 billion annually. Those billions of dollars tell a story of heartbreaking individual costs for our families. They tell a story of strained family finances, sometimes to the breaking point; of lost legacies and dismal and sometimes frightening ends to otherwise good lives. This can happen to each of us either through a brush with cancer or some other terminal illness.

When Social Security is taken out of our checks we believe we have entered into a contract and that that contract includes disability. The five month waiting period violates that contract at a time of the greatest possible stress for a patient and his family. We at the American Cancer Society believe this law must be changed as soon as possible. If the only way to do it is to have this study conducted first, if the rightness of the action is not evident on its own, then let us finally get these statistics and put and end to the question of how much it costs. It is our profound hope that the Congress will then be able to proceed with the business of eliminating this cruel imposition on those of our citizens who are dying and need this important income supplement to which we firmly and unequivocally believe they are entitled.

We greatly appreciate the efforts of Representatives Swift, Chappell and Matsui as well as the Chairman. We are deeply gratified that almost 120 of your colleagues agree that what we are asking is right and fair. We are equally grateful for the support over these last years from Senator Jackson. We hope this Congress will finally address this issue and resolve it. We herein commit ourselves to support the work of the sponsors of this legislation in any way necessary and urge the members of this Committee to at least consider the pain and suffering caused by this provision of the law. We believe upon careful consideration that you will want to attempt to find an equitable solution.

Mr. SWIFT. Four years ago I was approached by Howard Dalton, a constituent of mine, who found himself in this position: He was financially able to take care of himself, but in the course of treatment, he met many others who were severely affected by the need to wait 5 months for the benefits. A man of unusual drive and energy, he devoted the last year of his life to changing the law.

Howard came to Washington and testified twice before House and Senate committees. On January 30, 1980, the Senate passed a bill waiving the mandatory 5-month waiting period; Howard died 1 week later, believing that he had been successful. However, the

House did not pass the bill, and subsequent efforts in the next session failed, too.

At that time he was testifying on behalf of legislation that I had introduced and I have introduced that in all subsequent Congresses. The current incarnation has 121 cosponsors, which is bipartisan in nature and runs from the most liberal Members of the Congress to the most conservative.

Howard Dalton's concern was simply if you paid into disability, and if you were found to be disabled under the existing rules that are there, and two physicians will also assert that you are terminal, that at that point your disability payments ought to begin immediately.

There are ample examples in the record in which the disability check arrives when the family gets back from the funeral. This is particularly true with cancer patients. It is particularly true with lung cancer, which was the disease Mr. Dalton had.

Howard lived to see this amendment passed in the Senate, where Senator Bayh and Senator Jackson, Senator Magnuson amended it on the floor. Senator Long walked into the conference, capitulating on the House position on this particular issue, and there was no opportunity to really consider it in conference. Since that time we have not been able to address the issue.

One of the things that is always raised about it is cost. I would like to make two basic points about cost. First of all, it seems to me that the social security estimates of the cost of this program have been terribly inflated. One of the things that that conference committee and former Chairman Ullman had promised was that the social security would, under a study it was making of hospice care, also do a study of the costs of implementing this particular bill.

No such information has ever been forthcoming from social security. No such study has been forthcoming. Figures have come forth which seem terribly inflated.

In talking with a physician who has treated cancer patients for 30 years, he made this point: He said cancer is not the kind of thing in which either the physician or the patient are going to rush into admitting that the patient is dying. The physician doesn't want to admit he is giving up nor does the patient want to admit they are giving up.

You are not going to have fraudulent cases of people rushing in saying, "I am dying, give me disability now." In fact, the contrary pertains. That under this legislation you would first of all have to meet all of the other criteria for disability, and then have physicians that would stipulate you were in fact terminal.

And his point was, physicians are reluctant to do that as are patients reluctant to do that. The bottom line is simply this. I don't believe it was Congress intent to have this loophole through which people who are terminally ill fall, so that they don't have the opportunity to get their disability benefits as those whose disabilties are not terminal. I don't think Congress intended that. And I think that is a loophole that Congress must close up.

I thank the committee very much for permitting my testimony today.

[The prepared statement follows:]

STATEMENT OF HON. AL SWIFT A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Thank you for giving me the opportunity to appear today before your subcommittee.

I want to bring to your attention an injustice in the present Social Security System. Under present law, a disabled person who has been diagnosed as terminally ill must wait for five months before receiving disability benefits. On the face of it, this may seem a prudent regulation. However, in practice, the wait may well represent the final five months of a person's life. This is a time of physical and psychological pain to the patient and the family. To add a financial burden unnecessarily seems unworthy at the very least.

Four years ago I was approached by Howard Dalton, a constituent of mine, who found himself in the position described above. He was financially able to take care of himself, but in the course of his treatment, he met many others who were severely affected by the need to wait five months for the benefits. He thought that was unfair and he did something about it. A man of unusual drive and energy, he devoted the last year of his life to changing the law. Howard came to Washington and testified twice before House and Senate Committees. On January 30, 1980, the Senate passed a bill waiving the mandatory 5-month waiting period; Howard died a week later, believing that he had been successful. However, the House did not pass the bill, and subsequent efforts in the next session failed, too.

The problem has been the cost. We all know the budget deficit has become enormous and we are all conscious of the need to husband our nation's resources with care. Getting accurate estimates of the cost of H.R. 507 has been nearly impossible, but we think most estimates made so far by the Social Security Administration are grossly inflated.

There may be the fear that waiving the five month waiting period will make it easier for thousands more to claim benefits. I feel there is a built-in control that would serve to limit the numbers of eligible disabled persons. There is a natural reluctance on the part of physicians generally to determine that a patient is terminally ill. The medical community searches for ways to save lives—to diagnose a patient as terminally ill is considered a defeat. Further, it is incredible to believe a cancer patient, for example, would psychologically capitulate to the disease simply to defraud the government of a maximum 5-months disability payment.

In summary, the disability regulations of Social Security were obviously designed without considering the situation of those who are terminally ill. Having paid into the system to insure some income should they become disabled, they find that because they are more than disabled—they are both disabled (can no longer work) and are dying—they cannot get their benefits in a timely fashion.

This oversight needs to be corrected just for equity's sake. The alternative is nothing more than saving money at the expense of American citizens who are dying. That is simply unworthy of this nation.

Chairman PICKLE. Thank you, Mr. Swift. We have your statement together with the cancer report document included in the record.

The Chair would ask the members if they have any questions.

Mr. ANTHONY. Mr. Downey, I would like to thank you for some of the statements you made concerning social security disability because they pointed out some of the same problems that Arkansas is now facing. The Governor of Arkansas, Mr. Clinton, came and testified before the Select Committee on Aging, and tried to make the committee aware of the conditions that presently exist.

Many of the cases that were reviewed were automatically reversed after they were sent to Baltimore. This created a great deal of frustration and anger about the system, to the extent that the Governor held a press conference when he returned to Arkansas stating that he may join the other States in suing. However, it seems that taking it to Federal court, is not necessarily the best solution since it slows down the process of correcting the initial problem.

You mentioned there were some court decisions. I would like for the record to recognize that in my area the Eighth Circuit Court of Appeals has jurisdiction, and the court has ruled that pain in and of itself can be disabling. Yet the administration, through its policy operation mangement systems rejects this notion.

So you have an automatic conflict. The judiciary says one thing and the executive says another. And the court has also ruled that great deference should be given to the report of the treating physicians, yet the POM's do not require this.

So again we have another conflict within the jurisdiction. And if you are like Mr. Jenkins, and have not retired from the Congress but are still practicing law, and are representing these cases, then you have the problem of fighting the bureaucracy, while at the same time trying to represent your clients, and abide by circuit court regulations.

To be quite frank with you, if I were a person on disability, fearful of receiving a letter, I too, would be angered and frustrated. It is people's lives that we are dealing with, and we must find a sensible solution to it.

I would like to thank my three colleagues who have pinpointed some of the problems and frustrations that the Members of Congress have encountered. I want to thank all three of you.

Mr. **Downey**. Thank you, sir.

Chairman **Pickle**. Mr. Gradison.

Mr. **Gradison**. Mr. Chairman, I would like to also thank our colleagues for their testimony which has shed light in an area which I am afraid more often has seen heat—more heat than light. Thank you.

Chairman **Pickle**. Well, we thank all of you gentlemen. We are glad to have your testimony. We will be in discussion of these points with you later.

At this time, we will call Mr. Simmons. I had hoped that Secretary of HHS Margaret Heckler could have come here today, particularly in view of the fact she had issued some sweeping changes here 2 weeks ago.

I would like to have talked to her about some of those changes. But we are pleased to have you here. We recognize your dedication because to this program and helping us find solutions.

Mr. **Shannon**. Mr. Chairman, I wonder if the subcommittee is going to attempt to schedule Mrs. Heckler at some later date.

Chairman **Pickle**. She has agreed to do so. She is going to be out of the city today.

STATEMENT OF PAUL B. SIMMONS, DEPUTY COMMISSIONER FOR PROGRAMS AND POLICY, SOCIAL SECURITY ADMINISTRATION, ACCOMPANIED BY LOUIS B. HAYS, ASSOCIATE COMMISSIONER FOR HEARINGS AND APPEALS, AND ACTING DEPUTY TO THE DEPUTY COMMISSIONER; PATRICIA M. OWENS, ACTING ASSOCIATE COMMISSIONER FOR DISABILITY INSURANCE; AND DONALD A. GONYA, ASSISTANT GENERAL COUNSEL, SOCIAL SECURITY DIVISION, OFFICE OF THE GENERAL COUNSEL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. **Simmons**. Mr. Chairman, thank you.

I am accompanied today by Louis B. Hays, Associate Commissioner for Hearings and Appeals, and Acting Deputy to the Deputy Commissioner for programs and policy; Patricia M. Owens, who I am sure the committee knows, she is our Acting Associate Commissioner for Disability; and Donald Gonya, on the left, Assistant General Counsel, Social Security Division, Office of the General Counsel of the Department.

I appreciate the opportunity to come here today to discuss what has occurred with the continuing disability review process since I last appeared before your committee some 7 months ago. Since that time, an important piece of remedial disability legislation has become law and is being implemented successfully, and an important series of far-reaching initiatives was announced by Secretary Heckler on June 7. Also, since that time, some additional problems and concerns have come to light. Some of these concerns are reflected in the issues in which the committee has expressed particular interest: The appropriate standards for determining disability, a moratorium on reviews in mental impairment cases, and a number of matters relating to the appeals process.

Since the implementation of periodic review, this administration has recognized the need for changes in the disability decisionmaking process, particularly in the periodic review process. Some of the hardships to beneficiaries that have resulted have stemmed from the review process itself. The sheer volume of reviews mandated in the 1980 amendments highlighted obvious flaws in that process, flaws which we have moved continuously to correct through a long series of administrative reforms beginning in early 1982. Today, our major priority is to make the disability decisionmaking process as responsive to the needs and concerns of the disabled as possible. Making the program more humane is the main thrust of our June 7 initiatives.

We have also supported legislation to make reforms that we could not implement administratively and worked with the Congress, and especially this committee, for over a year on remedial legislation. These efforts culminated in the enactment of essential legislation, Public Law 97-455 in early January.

We are hoping to see another bill this year which we are looking forward to working with you on. We realize that more still needs to be done. For example, we need to consider the continuation of benefits for those who appeal termination decisions, since the provision in Public Law 97-455 for continued payment does not apply to termination decisions made after the end of this fiscal year.

However, at this point, I want to mention two problems with periodic review which we cannot address through administrative changes, and which the Congress cannot address by legislative action short of a wholesale change in the law. I believe too many people have lost sight of the central role these two problems have played, and will surely continue to play, in the controversy surrounding the disability program.

The first problem is that the public and beneficiaries fail to understand that the program provides benefits only for those whose disability is so severe and remains so severe that they are totally unable to work at any job anywhere in the economy, not just their previous job, but any job at all.

Social security disability is not like military disability or State worker's compensation or most of the 40 or so public and many private programs that pay disability benefits. The disability program does not recognize partial disability and does not permit beneficiaries to continue collecting benefits indefinitely after returning to work as many other programs do.

What Senator Pepper and others of your colleagues raised this morning is indeed a very large question, and that is what is the basic intent of the law and should we change that law to extend coverage for conditions other than disability which is what you are really talking about when you talk about unemployment patterns and so forth in the economy.

The second central problem flows from public, and beneficiary, misunderstanding of what the 1980 congressional mandate really means. In very real and very human terms, the periodic review mandate represented a drastic change in the rules of the program. Prior to the 1980 amendments, very few disability beneficiaries were ever reviewed, maybe only 5 percent a year, sometimes less than that. Indeed, that is one of the reasons for the 1980 amendments. Now, as many as one-third of the nonpermanently disabled must be reviewed each year. Many of those now being reviewed never expected that this review might one day happen.

Many of these people were placed on the rolls in the early to mid-1970's when caseload growth was swamping the program and administration was far more relaxed than it was to become in the late 1970's. In their own minds, rightly or wrongly, these beneficiaries were retired on disability for life. No one warned them they might one day be asked to prove their continued eligibility.

People coming on the rolls today know from the outset that their cases will be subject to periodic review. That is as it should be. That is as it should have been in the early 1970's.

Many of the hardships that have resulted in the course of the CDI review process are directly attributable to these two central problems.

Now, let me summarize for you the actions we have taken to implement the two major provisions of Public Law 97-455. The provision to pay benefits through the ALJ hearing for those whose disability benefits were terminated has been implemented so that there is no break in benefit payments for those who are electing to have their benefits continued. So-called pipeline cases were paid promptly. Most eligible beneficiaries were notified within 45 days after enactment.

We have conducted pilot programs to test the provision for an evidentiary hearing at reconsideration in three States—California, New Mexico, and Texas—so that we can more smoothly and effectively implement the provision nationwide before January 1984. We strongly supported this legislation because we knew it would result in more correct decisions earlier in the appeals process and thus reduce the number of ALJ appeals. Results of the pilot project bear this out; the allowance rate under the pilot was more than double the rate under the paper reconsideration process.

We have high hopes that nationwide implementation of this process in January will go far toward remedying many of the problems at issue here today.

While the administrative and legislative reforms that have been implemented to date have gone far toward making the CDI process more fair, humane and effective, additional experience, along with consultation with congressional leaders, the States and interest groups, has pointed the way to the further major reforms announced by Secretary Heckler on June 7. These reforms will insure that this program is more responsive to the needs of beneficiaries while still assuring that we fulfill our obligations to Congress and the taxpaying public to administer the program in an efficient and effective manner.

I want to describe briefly some of our June 7 initiatives. A complete list of our prior initiatives is attached to my statement.

We have reduced the number of beneficiaries to be reviewed every 3 years by expanding our definition of permanent disability. Those exempted include substantial numbers of beneficiaries with mental impairments who have been particularly hard hit by periodic review. Now, roughly 40 percent of disabled worker beneficiaries are exempted from the 3-year review.

I might add that is up from 27 percent exempted when we took office.

Based on program experience, SSA has concluded that mentally impaired beneficiaries with functional psychotic disorders are the most prone to incorrect terminations. Part of the difficulty is that diagnosis, treatment, and standards of measurement of these disorders are very controversial. Therefore, we have suspended review of such cases, representing roughly two-thirds of all mental impairment cases, pending consultation with mental health experts on revisions to our present standards and procedures for all categories of mental impairments. Once revised standards are adopted, we will take another look at already-terminated beneficiaries with functional psychotic disorders in order to make sure that they were not incorrectly terminated.

We have also made permanent two other kinds of mental impairment cases: Those with organic brain syndrome, and those mentally retarded whose IQ is between 60 and 69, and who have another physical impairment. Those two actions bring the total number of mentally impaired exempted to probably over 80 percent of the entire caseload.

SSA will now use a random selection formula to identify cases for periodic CDI review. We had been selecting cases based on a profile of characteristics found to be common to those most likely not to be disabled. Profiling caused a high number of terminations and a backlog of appeals of those terminations. While we clearly did not target reviews on the mentally impaired, the use of profiles has also resulted in a disproportionate number of mental impairment cases being selected for review, since such cases were more likely to fit the profile than cases involving physical impairments. For example, the reviews were targeted primarily on people under age 50, and a disproportionately large share of beneficiaries with mental impairments are under age 50. Random selection should spread the remaining terminations over the balance of the 3-year cycle, thus easing the appeals backlog. In addition, it should eliminate concerns that SSA is deliberately targeting reviews on the mentally impaired or any other group.

To remove a possible bias in the program toward denials, we are again proposing a change in the preeffectuation review provision. The 1980 disability legislation required that after fiscal year 1982 we review at least 65 percent of favorable State agency decisions on a preeffectuation basis. No parallel mandate to review unfavorable decisions exists, although SSA, on its own, has been reviewing unfavorable determinations to the extent that our resources permit. The imbalance in reviews of favorable and unfavorable disability decisions could create a bias toward more unfavorable decisions. We are therefore proposing that Congress change the statute to give us the flexibility to review both favorable and unfavorable decisions and to review whatever percentage of cases would result in the best quality of decisions in the most cost-effective manner.

That principle was embodied in the bill reported out of this committee last year, as you know. We hope to see his come out again, and we will suggest some language.

We are also proposing that Congress replace the temporary provision to continue terminated disability benefits through the ALJ hearing with a permanent provision to pay the benefits until the beneficiary has a face-to-face hearing. Once the provision in Public Law 97-455 which provides for a face-to-face hearing at reconsideration is fully implemented, we would propose to continue benefits only through reconsideration. We believe the crucial factor in giving the terminated beneficiary a chance to state his case is to provide a face-to-face hearing before the decisionmaker. Providing a face-to-face meeting at reconsideration should therefore result in a more accurate decision earlier in the process.

Other initiatives under way, such as training and improved case development, should also improve the quality of decisionmaking and result in fewer incorrect cessations. Thus, we believe that it is appropriate to pay benefits only through reconsideration.

Finally, SSA is accelerating its top-to-bottom review of disability policies and procedures, in consultation with appropriate experts and the States. For example, we are reviewing the eligibility criteria in both physical and mental impairment cases, and whether the "non-severe" impairment standard needs to be changed to better ensure that in a borderline case a full review of the person's age, education and work history is undertaken before any decision is made.

Next, I want to turn to some of the issues in which this committee has expressed particular interest. The first is the question of the appropriate standards for determining disability and the need for a moratorium in mental impairment cases until the standards are reviewed and revised if necessary.

We agree that disability decisionmaking standards need to be reviewed and that is why we have initiated the top-to-bottom review of our policies and procedures that I have just discussed. A major part of this review is examining whether a medical improvement requirement for terminating disability beneficiaries should be adopted. We would like to work with this committee to develop standards that take into account medical improvement without permitting clearly ineligible beneficiaries to remain on the rolls. It may be desirable to spell out such a standard by statute to avoid prolonged litigation on this subject.

However, we do not think that a legislative moratorium in mental impairment cases is needed because we already have initiated administratively a partial moratorium, which applies to roughly two-thirds of all mental impairment cases. This moratorium will remain in effect until we review our standards and procedures in mental impairment cases. We also think that many of the other reforms we have instituted will have a favorable impact on the mentally impaired and obviate the need for Congress to enact a moratorium.

Let me mention some of these initiatives. SSA now begins each CDI with a face-to-face interview, which should be especially beneficial to the mentally impaired. This personal contact with SSA should help them to cope with the stress of a CDI, and the contact enables us to identify their special needs and provide extra assistance if warranted. Also, the interviewer is able to provide observations about the mentally impaired beneficiary's conduct, appearance, and apparent ability to comprehend and to relate to other people. This information is helpful to the State agency in making the disability determination.

We have made improvements in obtaining and evaluating medical evidence in CDI cases involving mental impairments. The State agencies are required to make every effort to obtain medical evidence from all the treating sources seen in the last 12 months and to consider evidence from the prior decision if the evidence is material or if the impairment is characterized by periods of exacerbation and remission. This last point is especially important for people with chronic mental impairments because over time they can exhibit wide variations of behavior and symptoms.

We have issued instructions specifically requiring disability adjudicators to evaluate chronic mental impairments in a long-range context. The person's longitudinal history must be considered and all available medical evidence, past and present, must be obtained to determine the frequency of symptoms and the adequacy of the person's functioning. Supplying the person's medical history to a physician performing a consultative medical examination should also help to assure that the person's medical history is fully taken into account.

Additionally, SSA has under way a study to test the value of obtaining more than one consultative examination in mental impairment cases where evidence from the beneficiary's treating source is incomplete or inadequate. This is intended to determine whether a person's mental condition can drastically change from one day to another. One criticism of SSA's practice of getting only one mental status examination has been that it gives a misleading "snapshot" of a person.

Shortages of psychiatric resources in the State agencies have been another problem. These shortages occur in part because State fee schedules are often too low to provide an incentive for physicians to participate in the disability program. SSA has encouraged the State agencies to increase the number of psychiatrists and psychiatric consultant hours available and has supplied resource materials which they can use in recruitment. We have also been working with the American Psychiatric Association to encourage recruitment.

Finally, the assessment of residual functional capacity is especially difficult in cases of mental impairments. Therefore, we have issued a number of instructions to clarify this evaluation process. We are also determining the best use of assessment centers or workshop evaluations in assessing residual functional capacity in cases involving mental impairments. We hope to develop a profile of the types of cases most suitable for workshop evaluations, a data base on workshop availability, and a protocol and standards for workshop testing. Workshop availability will be a major problem in this process.

Next, I would like to turn to issues which relate to the appeals process. The first of these issues is the current procedure for establishing Federal disability policy for the various levels of the adjudicative process. As a result of a study by GAO, the Bellmon study and the early results of the Bellmon review, it became evident that there were inconsistencies in interpretation of policy between the various levels in the SSA adjudicatory system as well as within the same level. Therefore, SSA started preparing a series of rulings to provide a uniform set of policy statements and interpretations for adjudicating disability cases. These rulings provide a further explanation of the standards already in the regulations. Rulings are issued by the Commissioner of Social Security and, by regulation, are binding on all components of SSA.

What we have done is essentially what was in the original version of this subcommittee's bill last year, which was not enacted.

I might add that SSA has been criticized for not making these rulings subject to public notice and comment. This criticism reflects a rather widespread misunderstanding of the nature and scope of the rulings. As I mentioned, the rulings do not change the standards set forth in the regulations but are merely interpretations of the regulations and agency policy. Each proposed ruling is carefully reviewed by our Office of the General Counsel to assure that it is consistent with existing law and regulations. The Administrative Procedure Act specifically permits an agency to publish interpretations of policy without going through the rulemaking process. And we follow the Administrative Procedure Act in this regard.

The next issue I will discuss is the relationship between ALJ's and SSA. SSA has always guaranteed the independence of ALJ's with regard to individual case adjudication. This independence is provided to protect the rights of the individual claimant to a full and fair hearing by an impartial decisionmaker. No attempt is ever made to influence the outcome of a particular case and ex parte communications from the agency are prohibited. Furthermore, there is not now and never has been a goal or quota established for acceptable allowance or denial rates.

ALJ's are further guaranteed freedom from agency pressure in their decisionmaking role through their appointments pursuant to the APA. In addition, their independence is protected by some specific mechanisms. For example, hiring and selection criteria and compensation are established by the Office of Personnel Management, not by the agency. Also, adverse personnel actions such as removals or suspensions may be taken only when good cause is established before the Merit Systems Protection Board after opportunity for a hearing before another administrative law judge, I might add.

Nonetheless, some concerns have been raised about whether this independence has been affected by two activities that have been undertaken in recent years. The first one is our implementation of the congressionally-mandated review of ALJ decisions—the Bellmon review—as required by the 1980 disability amendments.

As you know, SSA conducted an implementation study and submitted a report to the Congress in January 1982 on SSA's progress toward implementing the Bellmon review. The major findings included: First, significant differences in disability decisions resulted when decisionmakers used standards and procedures governing State agencies than when they used those governing ALJ's, and second, there was a higher probability of error in favorable decisions of ALJ's with high overall allowance rates.

SSA implemented an ongoing review, beginning in October 1981. Our implementation report to the Congress described virtually all our plans for implementation. We initially decided to use allowance rates as the basis for selecting ALJ's for review based on congressional intent and the Bellmon report finding that decisions of high-allowance ALJ's would be the most likely to contain errors. However, once under review, the ALJ's allowance rate became irrelevant; the sole criterion for keeping or removing ALJ's from review was and is the accuracy and quality of their decisions. In April 1982, the Bellmon own-motion review was enlarged and the case selection criteria were redesigned and expanded. We added a national random sample of all ALJ allowance decisions, referrals from the SSA component responsible for implementing ALJ decisions, and decisions of newly hired ALJ's. Most importantly, at the present time, we no longer use individual ALJ allowance rates in selecting ALJ cases for review. ALJ's are being placed on review or removed from review on the basis of quality and accuracy of their decisions and without regard to whatever their allowance rates might have been. I would also like to mention that we have placed under review those ALJ's with the highest error rates in denial decisions.

The second area of concern is the allegation that SSA has a goal or quota requiring individual ALJ's to produce a given number of final dispositions per month. No such goal or quota exists and no improper pressure is applied to ALJ's to increase their productivity.

SSA's hearing workload is large and continually increasing. Hearing requested received in fiscal year 1982 reached a record high, and our pending caseload has also increased. To address this situation, we have taken a number of steps that enable ALJ's to make more case dispositions, and we have also hired 140 more ALJ's. A list of the major steps we have taken to assist the ALJ's to increase overall productivity is attached to my testimony.

I believe that increases in ALJ productivity are the result of our administrative efforts to give the ALJ's the resources they need and of the dedication and desire of all Office of Hearings and Appeals field staff to provide as many claimants as possible with full, fair, and timely hearing decisions.

Next, I want to discuss two improvements in the appeals process. The first is the provision in Public Law 97-455 which strengthens the reconsideration process by providing a face to face evidentiary hearing at reconsideration. I have already mentioned the favorable results of our pilot testing of this provision.

This reform is important because it will convert the reconsideration process from a paper-oriented review into a people-focused review. It will help assure that the first level of appeal in CDI termination cases is equitable and meaningful and results in prompt and accurate decisions earlier in the adjudicative process. However, the beneficiary will still have the right to request an ALJ hearing with all the rights he has now, if he is dissatisfied with the outcome of the reconsideration hearing.

We think that strengthening the reconsideration process in this way is far preferable to eliminating reconsideration as some have suggested.

We believe that the face-to-face reconsideration procedure required by Public Law 97-455 is a desirable innovation in the disability appeals process. By allowing the beneficiary to meet face to face with a decisionmaker at the first level of appeal, the new procedure will be more responsive to the beneficiary than the existing reconsideration process, and will also make more information about the beneficiary's condition available to the decisionmaker. It would seem imprudent to eliminate the reconsideration stage when SSA is just now on the verge of implementing this useful, congressionally mandated improvement in the reconsideration process.

Besides improving both the quality of case record development and the quality of decisionmaking at the reconsideration level, the face-to-face reconsideration process will alleviate some of the burgeoning workload growth and resulting backlogs at the ALJ hearing level by allowing more appeals to be resolved at the lower level. We would anticipate a very deleterious effect on the ALJ workloads, by contrast, if the reconsideration stage were eliminated. Even assuming some increase in the number of initial allowances as a result of the proposal to eliminate reconsideration, that proposal would almost certainly inundate the already-backlogged ALJ hearing level with still further appeals. For this reason, we strongly question the wisdom of eliminating reconsideration or consolidating it with the initial determination stage.

The other legislative change we support is one I discussed in connection with our June 7 initiatives—the continuation of disability benefits for terminated beneficiaries through the evidentiary hearing.

Public Law 97-455 provides that a social security disability beneficiary whose benefits have been terminated may elect to have the payment of social security and medicare benefits continued up until the month before an ALJ makes a hearing determination. This provision is temporary; it applies only to cessation determinations made before October 1, 1983, and does not permit continued payments beyond June 1984.

We propose permitting the continuation of benefits through the month of the first appeals decision where the appeal included a face-to-face evidentiary hearing. Now, the first opportunity for such a hearing occurs at the second level of appeal, the ALJ hearing, but by January 1984, the reconsideration process, the first level of appeal, in CDI cases will include a full evidentiary hearing before the decisionmaker.

We support placing in the law a permanent provision to alleviate hardship for social security disability beneficiaries who appeal terminations. However, we think it is unnecessary to continue social security disability benefits up until the ALJ decision. We must keep in mind that for the first 25 years of the program, there were no benefits paid pending appeals of a termination. We believe Congress placed the temporary provision in the law for two reasons: Perceived problems with the periodic review process, and the fact that the ALJ hearing was the first face-to-face appeals step. We have remedied both of these problems.

You also asked that I address our policy on compliance with court decisions. SSA is bound and abides by all final judgments of Federal courts with respect to the individuals named in particular suits unless and until the judgments are reversed on appeal. SSA does not, however, consider itself bound with respect to nonlitigants by each decision of the various district and circuit courts.

The executive branch could be considered to be abdicating its responsibilities if it turned over the determination of agency policy to each of the 94 district courts or 12 circuit courts that might render an opinion on an issue. In addition, often within the same district or circuit, judges reach different decisions on the same issue. In a program of national scope, it would not be equitable to claimants and beneficiaries to subject claims to differing standards depending on where they reside. This is especially true with respect to cases where the court decision is inconsistent with established SSA policy.

Therefore, where a lower court's decision is contrary to the Secretary's interpretations of law and regulations, SSA has a longstanding practice of publishing a ruling stating that SSA will not adopt the court's decision as agency policy. There are only seven such rulings in effect now.

There are several reasons why SSA does not recommend appeal to the Department of Justice of all lower court decisions that are contrary to the Secretary's interpretations of law and regulations. For example, if the same issue has been decided by a number of courts and the weight of the decisions agrees with the Secretary's interpretation, SSA may decide not to recommend appeal of the minority of cases which disagree with the Secretary's interpretation. On the other hand, if the weight of the court decisions on a given issue does not agree with the Secretary's decision, SSA generally recommends appeal of one or more of the cases. In this situation, however, it would be inefficient to appeal every unfavorable decision, and SSA selects the case or cases that clearly present the issue to be decided and tries to avoid appealing those cases where consideration of the larger issue could be clouded because the specific facts in the cases are not clear. To appeal all such cases would be administratively expensive, would constitute an inefficient use of limited Federal legal resources, and would aggravate the already heavy burden of litigation in Federal courts.

Finally, in some situations, the majority of court decisions involving an issue may disagree with the Secretary's interpretation and remedial legislation by the Congress may offer an alternative to resolution through the judicial process. For example, a number of courts have ordered SSA to pay interim benefits before making a final determination of entitlement in cases where the courts believe SSA has taken too long to resolve administrative appeals. Social security law clearly does not permit SSA to pay these interim benefits, and the administration supported legislation in Congress last year that would have amended the Social Security Act to further clarify that these interim payments are not permitted. However, these decisions are also being appealed.

In closing, I want to reiterate that we are committed to improving the CDI process. We will continue to work closely with professional groups to get suggestions for change so that we can make our program as humane and fair as possible. We will continue to do everything within our power to assure that due process of law is provided to claimants in an adjudicative setting that is free of prejudice or inappropriate constraint, and that the social security disability program is administered uniformly in a socially and fiscally responsible manner. We will also continue to work with this committee and Congress to make further legislative improvements in the disability program.

May I add one personal note, Mr. Chairman? Earlier, we talked about the political football that this program has become—and indeed, it has in many cases. We have had hearing after hearing, we have had story after story, and sometimes there is much more heat than light being shed on the subject.

There is one thing I would like to point out. One of the key indicators in how this program is being run is the initial allowance rate, people entering the system. That is one statistic that doesn't lie.

And it says a lot about what the climate is of this program. In the 4 years of the Carter administration, preceding the 1980 amendments, preceding our coming into office, that rate fell from 48 percent in 1977 down to around 28 percent in 1980, a drop of 20 percentage points, almost in half.

Since we have taken office, it went down 1 more percent, but it is now going back up. I think that that measure indicates that we are sincere in the reforms we are making, we are sincere in cleaning up the adjudicative climate in this program.

I think the pendulum did swing too far in reaction to the 1980 amendments and indeed, the 1980 amendments themselves. We have said that time and again. This is a very complex program. As one of your colleagues pointed out, determining who is disabled and who is not is probably the toughest thing the Government does.

But we are making good faith efforts to change the system. The efforts that we began making last year with the first reforms that Commissioner Svahn ordered show up in the allowance rates up front.

I think that is significant.

[The attachments to Mr. Simmons' statement follow:]

ATTACHMENT 1

MAJOR CDI REFORMS INITIATED PRIOR TO JUNE 1983 INITIATIVES (ANNOUNCED BY SECRETARY HECKLER ON JUNE 7)

1. In October 1982, SSA started using a new procedure for beginning a CDI review: each beneficiary has a face-to-face interview with an interviewer in a local Social Security office. The interviewer explains how the review works and what the beneficiary's rights are, obtains information about the beneficiary's medical care and treatment and current condition, and—in some cases—concludes the review process where it is clearly warranted based on the beneficiary's current medical condition.

2. SSA is stationing State agency employees to serve as disability consultants in many SSA local offices with the highest workloads to provide additional disability expertise. New interview forms and guides have been issued to local office interviewers and numerous State agency disability consultants are already on site.

3.SSA established pilot programs in three States so that SSA can smoothly implement the provision in Public Law 97-455 providing an opportunity for a face-to-face evidentiary hearing at reconsideration. Prior to the legislation, SSA had been planning to implement this change on an administrative basis.

4. In March 1982, SSA initiated a policy of determining that, in general, a person's disability ceases as of the time the beneficiary is notified of the cessation. This change reduces situations where the beneficiary is faced with the need to pay back past benefits because of a retroactive determination.

5. Since May 1982, SSA has mandated that States review all medical evidence available for the past year—a directive which ensures that every State is looking at every piece of evidence that might be pertinent to a case.

6. SSA has taken many actions to improve the quality of consultative examination purchases by the government in cases where medical evidence from a person's physician is unavailable or incomplete.

7. Since March 1982, SSA has required State agencies to furnish detailed explanations of their decisions in all cases in which a person's disability has ceased.

8. To improve the quality of determinations in difficult cases where it is necessary to determine a person's capacity to do work-related activities despite a severe impairment, SSA is requiring that the determinations as to residual functional capacity be more detailed and explicit so that the basis for the final decicion is clear.

9. To ensure quality in CDI cases, SSA conducts a quality review of a sample of cases before benefits are stopped. In addition, to demonstrate the importance of quality in the CDI process, SSA established an interim accuracy goal for the State agencies. SSA is also studying terminations to find out what kinds are especially error-prone.

10. SSA has consistently monitored State agency resources and workloads closely and adjusts the flow of cases to the individual States to avoid backlogs when problems have arisen in their acquiring adequate resources.

11. SSA refined the selection criteria for CDI reviews so that more beneficiaries who are permanently disabled were identified and exempted from the 3-year review process.

12. To modernize the CDI process and make it more responsive to beneficiaries' needs, SSA has reached out to many public and private interest and professional groups to discuss their concerns about the disability program and to obtain their suggestions for improvements. SSA has also met extensively with State agency administrators and field personnel to exchange ideas for improvements.

13. SSA has concentrated efforts on the need for special handling of cases involving psychiatric impairments:

SSA has also encouraged the States to increase the number of psychiatrists on their staffs and has asked the American Psychiatric Association (APA) for assistance in recruiting psychiatrists for the States.

SSA and the APA have agreed to exchange research and development information in the field of mental illness.

SSA has issued instructions emphasizing the importance of evaluating chronic mental impairments in a long-range context. The instructions require that disability adjudicators consider the person's longitudinal history and obtain all available medical evidence, past and current, to determine the frequency of the person's symptoms and the adequacy of his functioning.

14. SSA has underway a study to test the value of obtaining more than one special mental status examination in cases where evidence from the beneficiary's treating source is incomplete or inadequate. This is intended to determine whether a per-

son's mental condition can drastically change from one day to another. One criticism of SSA's practice of getting only one mental status examination is that it gives a misleading "snapshot" of a person.

15. SSA has been issuing Social Security rulings to make sure that all disability decisionmakers—State agencies, ALJ's and the Appeals Council—follow the same standards of adjudication. These rulings are in accord with existing law and regulation and do not establish new standards.

16. SSA has added more than 140 Administrative Law Judges to what is already perhaps the largest single administrative adjudicative system in the world, bringing their total number to almost 800 and providing them with significantly more support staff to help reduce the backlog of cases that has been a chronic problem in past years.

17. SSA has issued to its field offices and to State agencies procedures for handling potential suicide situations to make sure that SSA and State agency personnel identify and give appropriate attention to beneficiaries who may be in this situation.

ATTACHMENT 2

ACTIONS TAKEN BY SSA TO SUPPORT ALJ'S IN MANAGING THE HEARING CASELOAD

SSA has hired additional ALJ's, bringing the current total to almost 800.

We hired 749 new supporting staff persons to raise the overall support staff to ALJ ratio.

SSA opened three regional hearing offices that assist hearing offices within their regions that have the greatest backlogs. We opened a national office that provides the same service to the other regions. These offices allow greater flexibility and efficiency in handling temporary increases in workloads or shortages of ALJ's in particular offices.

We have upgraded the office equipment in our hearing offices to enable staff to perform case processing functions more expeditiously.

We are experimenting with innovative organizational structures and methods of processing the workload. We established a Hearing Office Innovations Staff to investigate innovative procedures used in the field and analyze their suitability or nationwide implementation.

Chairman PICKLE. Well, Mr. Secretary, of course, we thank you for your testimony and for your statement. What you have said and the views you have presented will have specific bearing on the committee's considerations.

I do have a lot of questions I want to ask you.

You end your testimony on a note of protestation. I don't know, as I have said, you have been involved in a political football. I think you are too sensitive about it, maybe for good reasons.

You may compare the Carter administration with the Reagan administration. I hope we don't try to hang on the percentages of cases handled by one administration as opposed to another.

We are trying to get to the basis of what we are trying to do. I have the feeling, Mr. Secretary, that you are almost—departing from our hearing here, but I cannot help reacting—I get the feeling the Congress is to be apologetic for what we have done and the job we have foisted upon you, and you have been pointing out the great harshness happening in this program, that we are finally doing what you have been recommending all along.

I thought just the opposite was the case. I almost have a sense of guilt this morning, as though we have been doing this poorly the last couple of years.

Here again, I hope we don't dwell on our individual feelings or preferences. Now, if you want to comment—since you started this little exchange—I will yield to you.

Mr. SIMMONS. I would never accuse you of playing politics with this program, sir. First, I said in general it has become a political football, as one of your colleagues pointed out. Second, we are not blaming the Congress for what has happened.

We are pointing out what the Congress did and how the program changed in reaction to that. There was the drastic change in the rules in effect, because prior to the 1980 amendments, nobody—hardly anyone—was reevaluated in this program.

Suddenly, people who had been on the rolls 5, 10 years, who never had been told they were going to be reviewed, are going to be reviewed. That was the change in the rules. But the process itself for 27 years chugged along with never a human contact with a decisionmaker in the program until you got all the way to the ALJ.

The Congress recognized that last year in passing Public Law 97-455, giving us the face-to-face reconsideration, and we recognized that defect in the system by moving administratively to start every review with a face-to-face interview up front.

We are catching the 5 percent or so who are the horror stories now through that process, which I think is a significant change.

Chairman PICKLE. You always had authority to review these cases. The law says you are to review the cases. But the administration was not reviewing the cases.

Mr. SIMMONS. That is correct.

Chairman PICKLE. Neither the Carter or Reagan administration, were not doing it. So because you were not doing it, and we felt there was a need to find out who were really disabled, we instituted the review process, a good process.

Now, what we have to do is try to make it workable and more humane. I hope we don't dwell any more on who caused this thing.

I just ask you parenthetically, why did the administration announce the big changes on June 7, about the disability program?

Mr. SIMMONS. Those flowed out of the study begun last year, the first reforms we did we announced continuously over the last year.

And then, this year, we have continued the effort to look at all of the factors in this program, all of those things in the policies and in the procedures that affect the outcome of cases, and we got together quite a group of needed reforms.

We took them before the President. Our initiatives would not have been announced on that particular date had they not leaked out of the Department and made it to the front page of the newspaper.

So, we had to announce them.

Chairman PICKLE. We always wonder how they leak out. You mean you had a mole down there?

Mr. SIMMONS. We had a mole, sir. It is very difficult, as you know, in this town to make policy without having it aired on the front pages.

Chairman PICKLE. It makes our problem more difficult here. Perhaps I am being personal now. We have been talking in this committee with the administration, close contacts, about changes we might make, should make.

We have been talking with disabled groups, talking to Members of both the Congress and the other body. And we were close to introducing a bill, had a date set. And then lo and behold, we woke up one morning before coffeetime and saw that the Secretary had made broad, sweeping changes, and hadn't called us about the time of day.

Now, I am not going to say some of the things you have done may not be a good thing. I question the timing, as far as we are trying to put together a bill here. Let's don't dwell on that.

Let me ask you some specific questions on your testimony. One with respect to the announcement made down the street, and the moratorium that the Secretary issued.

Senator Heinz has placed in a supplemental appropriation bill a moratorium affecting cases of mental impairment. Do you think we should have a legislative moratorium?

Mr. **Simmons**. We don't believe that we need a legislative moratorium, particularly one that is crafted in the way that particular amendment is.

First of all, we think it goes too far, that it covers groups of people that do not need to be covered by it.

Second, it would build into the law in perpetuity a procedure by which all decisions in the future would be made.

For example, it says that all decisions henceforth on any mental case would have to be made by a psychiatrist or a psychologist, even though in a great number of cases an M.D. trained in psychiatric specialties might be able to automatically rule in a case based on the evidence and say this person has a disability.

When we have very scarce psychiatric resources available to States around the country, we think this would spread the resources too thin and some cases might have to be sent out of State to be looked at, because there would not be anyone there to do the work.

We also think putting such a procedure into the law gives you something that will never change. For example, the Congress wrote the 1967 Federal interagency daycare standards into the law and then proceeded for 14 years to suspend them, but they could never get them out, because they could not get the votes together to say we don't want those rules.

We don't think that is a good way to make policy

Chairman **Pickle**. Let me ask you this: You are talking about the moratorium. In the Secretary's initiative, she announced the moratorium on review of individuals disabled because of functionally psychotic disorders and estimated that would affect about 135,000 people.

Now, does this moratorium include the review of individuals under this category which were already underway? That is, reviews already in the pipeline. Or is it limited only to reviews which would have come after June 7?

In other words, if the Secretary's moratorium does not include those cases in the pipeline, why did she not include them?

Ms. **Owens**. The moratorium includes cases in the pipeline.

Chairman **Pickle**. If you include those in the pipeline, how many more would that include?

Ms. **Owens**. When we gave that figure of two-thirds, or the figure that you just read, that included all the cases that were either currently in the pipeline or were yet to be pulled from the files.

Chairman **Pickle**. Well, we have this question.

Mr. ANTHONY. Would the chairman yield?

Chairman PICKLE. I will yield.

Mr. ANTHONY. In talking about some of my colleagues, this particular area has raised a great deal of concern. In fact, I am a cosponor on a piece of legislation that would try and bring some corrective legislation into effect.

But I am under the impression that there have been contradictory answers given to Members of Congress about this very same question; that when asked, the Department has said that some of the cases that are presently in the pipeline and under review would not be covered under the moratorium.

I am talking about the functionally psychotic and in response to Mr. Pickle's question, you state emphatically that the moratorium does cover them.

In other words, if I were representing a functionally psychotic individual, and I had been brought in and was in the process of the review, and then the moratorium was issued, then my case would have automatically been pulled out of the appeal process.

Ms. OWENS. That is where there is a distinction.

Mr. ANTHONY. This is what I am afraid of, that we are sitting here playing on words.

Ms. OWENS. I want to be sure we don't do that.

Mr. ANTHONY. We are going to get it real clear.

Ms. OWENS. The functionally psychotic cases on which a cessation decision has been made, which are in the appeals process, a person has asked for reconsideration, or they are in front of an ALJ, those are being processed through.

The ones in the pipeline that I referred to are cases where there has been no decision. It doesn't matter whether they have been developed. We may have gotten some evidence.

Any point in those cases where a cessation decision has not been made, action is being stopped. But it is true that cases where a cessation decision has been made and that are at appeal, at reconsideration or at the ALJ, we are continuing to process those.

Chairman PICKLE. May I reclaim my time?

Mr. ANTHONY. Yes, sir. But I would like to be recognized afterward to speak on this point.

Chairman PICKLE. One of our colleagues has raised this question. We are advised it did not include the people in the pipeline. He has written to Secretary Heckler 2 or 3 days ago, or least a week.

I will read you one paragraph of his letter:

> I have learned that the Social Security Administration has changed the rules in midcourse and that functionally psychotic disorder cases currently under review will be treated as any other disability case.
>
> That is those persons who have received notification of review or who are in the process of review must continue in the process under the old criteria.

And it goes on.

[The letter follows:]

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., June 23, 1983.

Hon. MARGARET M. HECKLER,
Secretary of Health and Human Services, Department of Health and Human Services, Washington, D.C.

DEAR MADAME SECRETARY: Following your Department's announcement of a new initiative to moderate criticism of Social Security disability investigations, I began to receive inquiries from constituents regarding the impact of the changes which you announced. I was particularly interested in determining the status of disability reviews for functional psychotic disorders, as this appeared to be both of major concern in the inquiries made to my office and of major uncertainty from press reports.

My staff contacted both the Social Security Administration Office of Congressional Relations in Baltimore, Maryland, and the Dallas Regional Office in Dallas, Texas, to determine the impact of the new initiative for this class of disabled persons. Both branches of your Department informed my staff—barely one week ago today—that new criteria were to be established for review of functional psychotic disorders and that until such time, all action on this type of disability case—no matter the current stage of investigation or review—would be halted and disability payments would continue. Accordingly, I informed my constituents of the determination that had been made by the Social Security Administration under your authority.

Today I have learned that the Social Security Administration has changed the rules in mid-course and that functional psychotic disorder cases currently under review will be treated as any other disability case, i.e., those persons who have received notification of review or who are in the process of review must continue in the process under the old criteria. In addition, it is my further understanding that your Department has decided that until new criteria are established, initial claims for functional psychotic disorder cases will be assessed under the old regulations.

I find this turnabout in Department policy appalling. I welcomed your attempt to treat the review of disability cases in a more organized and humane manner than was previously undertaken by this Administration, and I had hoped that the new initiative you announced would ease some of the material and emotional hardships which had been placed unnecessarily on persons receiving Social Security disability payments. However, the action taken today seems only to reinforce the impression that your Department is unaware of the despondency of many of the good Americans who have no place other than the federal government to turn in order to receive adequate benefits to survive in our society. No one can estimate the amount of mental strain and anguish which such poor planning and indecisiveness within your Department will cause to this group of people in particular.

I would hope that you will look into this matter more closely and that you will inform me of what actions you anticipate taking to correct the situation we now face and to prevent a similar occurrence in the future. Thank you for your attention to this matter, and with every good wish, I am

Sincerely,

JACK BROOKS.

Chairman PICKLE. Now, apparently he had been told one thing, and then a week later just the opposite. This is from my colleague, Jack Brooks—he is not a very bashful individual. I think you will want to try to answer that. And also, along the lines Mr. Anthony has raised.

How long will this moratorium last?

Mr. SIMMONS. Until we have acceptable standards. It could be a matter of a few months, it could be even longer than that, depending on how long it takes us to get agreement with outside experts and among ourselves on what are going to be the acceptable standards.

Chairman PICKLE. Or unless Congress passes a law with standards.

Mr. SIMMONS. I don't think that you could. I think you would run into the same problem that we have already run into on coming up with such a standard that is acceptable.

I think it is going to be very difficult. I am talking here about the medical standard of how you measure mental disorders, coming up with something that is acceptable to the professions and something that is manageable is going to be very, very difficult.

Chairman **Pickle**. I am going to ask one other question about standards. The Chair is going to announce we will recess at this time. We will resume the hearings at 11:15.

[Recess.]

Chairman **Pickle**. The Chair will ask the subcommittee to come to order again. We are going to proceed.

We may be facing a series of votes and we may be called back to the floor. I suggest we proceed.

Mr. Simmons, I was going to ask you a question with respect to the policy regarding the uniform standards. Let me state the question to you.

In the testimony you have just given this morning, you stated that your approach to uniform standards of adjudication is to put all interpretations of policy into SSA rulings.

Mr. **Simmons**. Yes, sir.

Chairman **Pickle**. Which are not open to public comment. You put it in the ruling rather than regulations because the Administrative Procedure Act allows interpretation of policy to be published outside of regulations.

Now, if there are such great differences between the State agency and the ALJ, as everybody must agree that there is these sharp differences, just because of differences in these interpretations of policy, doesn't that mean there are real differences in the policy itself?

It seems to me that any difference—that means one person gets the benefits while another doesn't—is pretty significant. My question to you is why shouldn't we put all these rulings into regulation, subject to open comment?

Mr. **Simmons**. Well, first of all, sir, you know that the rulings are based on regulations and based on interpretive material, the so-called POM's. They are a condensed version of what the operating policy is at all levels. Our principle in doing this is to make sure that the system does have the same set of rules that goes all the way through the process.

So, when a person approaches the system he or she knows what to expect out of the system. Our policy of doing it by rulings rather than going through the entire Administrative Procedure Act rigmarole of public comment on every single thing we do is based on the need of this program, within the broad statement of policy which is in the regulations, to be able to move rapidly on something.

For example, when we interpreted our own rules earlier this year, just a couple of months ago, to say that AIDS is automatically an entitlement factor—we did that almost overnight.

We did the same thing when Public Law 97-455 was passed, when we got the continuation of benefits; we had our instructions out within a matter of weeks after the President signed the bill.

If we had to go through rulemaking every time we did something, we would not be able to do things nearly as fast. Even if you go to an interim final rule on something, it can take you 6, 8, 10 weeks to do anything.

Chairman **Pickle**. This problem of rules versus regulations is a pestering and festering thing. We cannot seem to make any conclusions. It seems to me like your problem is neither the Congress nor the public nor the courts or the public in generally knows what your policy is.

We don't really know. Once you have your rulings, and you have established them, you know what they are, why don't you then put them into regulations and be done with it?

Why can't you proceed on that basis? What harm would it do if you did that?

Mr. **Gonya**. Mr. Chairman, in addition to everything that Mr. Simmons pointed out, I would also point out if you look at the subject matter and the specifics and the details that are contained in some of these rulings, believe me, they just are not intended to be subject to the Administrative Procedure Act or to be put in regulations.

They are operational procedural statements, they are matters that I do not believe the Administrative Procedure Act ever envisioned would go into a regulation. As Mr. Simmons pointed out, the basic policy is in the regulations and the Social Security Administration has been particularly successful when court cases have been brought challenging materials that are in the manuals. The courts have said that such materials are appropriately in the manuals, and in the rulings, and they do not belong in regulations.

Chairman **Pickle**. Well, this may be a question that we are not going to have any meetings of the minds. And I have in the past decided pretty much we ought to go slowly and eventually put these rules in.

By the time we get a ruling on something, and you postpone it 6 months or a year, it seems to me there is a big gap. The public doesn't know where they stand. Nobody knows what the policy is, because it is your policy and your ruling.

I think we are going to have to find a better and quicker way to establish these things. I don't want to say this is the committee's policy. But it bothers me that we still fall back on the old procedures. It ought to be more open and clearly administratable. It seems to me we could do it.

What about the rights of the people being knocked off? They are affected. I know you passed the rule on AIDS. That is good. But I think you can do it on others.

Mr. **Simmons**. Some of the proposals that we have seen would have us put the entire instruction manual into regulations. And that is like 20,000 pages right now—20,000 pages of material associated with this program. A lot of it has to do with bookkeeping, with how you reimburse, how you do this, that, and the others.

A great bulk has to do with that. But if you went into a situation where every time you had some interpretation of policy, or some State writes in and says, "I have this particuliar case, it is a particular problem"—and so our experts look at it, our doctors look at it, and say it should be handled this way and any other cases like this should be handled this way—you had to handle that as proposed rulemaking, you could never get an answer back to the State. You could probably do far less fine tuning of the program than you can do now.

Chairman **Pickle**. I am not trying to rush out and make you have to operate on an instantaneous new basis. But I am concerned that you have rulings and we have regulations. The State agencies are governed by one set of rulings and regulations, the ALJ perhaps by another.

Mr. **Simmons**. No. They have always been subject to the same regulations. They are how subject to the same rulings.

Chairman **Pickle**. We are closing that gap some. But there is still a great discrepancy about what should be the basic policy. Somehow in between this slow moving curtain behind which you work, it seems to me, we ought to have a more open and easily discernable policy.

I don't know what that level is. But we ought to look at it some other way.

I will continue with one other question.

Do you want to ask any questions at this point, Mr. Shannon? Let me ask this——

Mr. **Shannon**. No, Mr. Chairman, I will wait until you finish.

Chairman **Pickle**. Mr. Simmons, do you have any data which would indicate how many individuals whose benefits have been terminated have shown medical improvement in their condition or who were found to be working?

Mr. **Simmons**. We are right now doing a very exhaustive study of a very large sample of cases, precisely with that in mind. We are looking at the medical improvement issue. As I said in my testimony, it may well be best to address that issue in the statute in some way. We are looking forward to working with you on that. We think from the early returns, from what we are getting from our review of cases, that in more than half of the cases there is medical improvement without question. Then the question becomes what other variations are there around. And this is a very big question.

If and when the Congress or we were to go back to the idea of using the medical improvement standard, which was only used for about 6 years during the entire history of this program, it should be remembered that it was done away with precisely because the States didn't want it, they did not want that in the rules because it was so hard to administer.

If we do go back to that idea, what Congress is going to be saying, in effect, is that we are going to use a different standard for those on the rolls than those who are now coming into the rolls in many cases. And you have all kinds of permutations. You have medical technology advances that have happened since a person went on. You have the viewpoint of the medical community about certain kinds of disability that change over time; certain kinds of illnesses used to be considered very serious, now they are not. So a lot of things would have to be factored into that.

A lot of loopholes would have to be closed up. Otherwise, you could have the program return to a wide-open mode that we just could not control.

Chairman **Pickle**. We had a statement made earlier by one of our colleagues saying in his opinion at the initial stage the burden of proof is really on that individual to prove. Once he got on the rolls, then that burden of proof ought to shift to the SSA to prove that there was or was not medical improvement. Did you hear that?

Mr. SIMMONS. Yes. The burden-of-proof issue keeps arising. I think it is hard to draw an analogy. You are talking here about an entitlement program, much like welfare, social insurance is an entitlement program. A person has to have certain criteria in order to meet the entitlement. This is unlike a criminal court proceeding where the presumption of innocence rests in the citizen being approached by the State and charged with a crime. In this case, if SSA were to presume people to be disabled and have to disprove it, you would in effect say, "Well, 227 million Americans ought to apply and see how many can get through."

And one final point: the proof really resides in the person. We cannot force a person to give us medical evidence. We cannot force a person to go to the doctor unless the rule of the program is, and this is in the law, that if you don't cooperate with us, you are taken off the program altogether. I don't think the term of art, burden of proof, applies here.

Chairman PICKLE. Let me give you what the staff feels is kind of a background for this, and let me ask you your comment.

The Social Security Administration has been criticized for stopping the benefits of people who have been on the rolls a long time and whose medical condition hasn't changed or improved any. A lot of people are proposing that we do not terminate benefits for anyone whose medical condition hasn't improved; a sort of grandfather approach. I am concerned about that, because if we do that, we may end up continuing to pay benefits to people who can work, maybe who shouldn't have gotten benefits in the first place.

Mr. SIMMONS. That is right.

Chairman PICKLE. But I can understand the concern of people who have not worked in many years, who suddenly lose their benefits. They have no place to turn to. They are just in a state of shock. Now, it looks to us, we have three approaches. One, you could grandfather in all those whose medical condition has not improved. You can say they are grandfathered for administrative ruling. Or you could grandfather in only those whose medical condition hasn't improved who also are unable to do their past work and could only work if they were able to retrain for another job.

In other words, a medical improvement test with an additional work ability test, kind of a combination. Or three, we could say we are not going to grandfather anybody in but continue benefits for all those who cannot work, considering their length of time on the rolls. What approach would you take on that?

Mr. SIMMONS. Your second approach, I think, where you would say that a person who can do their own past work would come off—those who would have to have retraining to go into another area would be another factor.

I would like Miss Owens to comment. We are looking at one crucial factor in this whole thing—whether or not we can take some time on the rolls as a factor in figuring out a person's so-called residual functional capacity—to say a person who has been on the rolls for years, that in itself is a disabling factor.

Ms. **Owens**. We have looked at a couple of things. One of those is a combination of age and time on the rolls as a criteria for entitlement under disability. We are also looking at things in the whole vocational area, such as relevant past work. We have some rules that say within the past 15 years, work is relevant. But now with the way the economy changes and—not so much the economy, but the technology changes—maybe 15 years is not a good period of time. Maybe you only look back at past relevant work for a 10- or 5-year period in some cases. So there is some work to be done to consider the vocational profiles and pictures of people in relationship to today's time and the fact that people are of a certain age and have been on the rolls for lengthy periods.

Chairman **Pickle**. If I understand you, you said you are now, in connection with these medical improvements, you are looking at such things as, did you say, the age?

Ms. **Owens**. A combination of——

Chairman **Pickle**. Time on the rolls, and past vocational factors.

Ms. **Owens**. The recency of work. The recent period of work that we consider as to when a person can go back to that kind of work or can be retrained for other work.

The age and time on the rolls has been a combination we have been thinking of. If a person is 55 and has been on the rolls 10 years, that combination of 65 is the one that has the most promise of being an additional entitlement factor.

Chairman **Pickle**. Thank you. I have other questions. I want to yield.

Mr. Shannon.

Mr. **Shannon**. Thank you, Mr. Chairman.

Mr. Simmons, I guess I have some of the same concerns that the chairman has about your analysis of what the problem is. You characterize it as a pendulum swinging too far. Now it is swinging back and everybody acknowledges that it has swung too far, and maybe it was the result of the 1980 election.

I was wondering whether you could tell us first of all what the administration's projected savings as a result of the CDI program are from the period 1982 to 1986.

Mr. **Simmons**. I have some numbers here for fiscal years 1983, 1984, 1985—just about the period you are talking about, I believe.

In looking at these numbers, you have to remember that the numbers that appear in the budget are the cumulative total, including the diary cases as well as the periodic review cases. If you look at only the incremental savings from periodic review itself, it is about $350 million for 1984, $250 million for 1985, and $150 million for 1986, minus about 20 percent, which we are taking out of that because the system now is at about 75 percent capacity, and we have exempted even more from the system. So that number will probably drop to the neighborhood of $600 million, and because of the reforms that we are talking about, will probably drop to about half of that.

Mr. **Shannon**. What are the budget figures you submitted for this year?

Mr. **Simmons**. The figures, I believe, that were in the budget, the total numbers were $1 billion for 1984, $1.25 billion for 1985, and

$1.4 billion for 1986. But that includes all savings from reviews—not the 1980 mandated reviews alone, but all reviews.

Mr. SHANNON. So there are other reviews which are being done.

Mr. SIMMONS. Yes. The normal diary cases and people who fall off the rolls. When you look at these numbers, they accumulate.

Mr. SHANNON. When we passed the bill in 1980, what kind of savings were anticipated?

Mr. SIMMONS. I don't know what the Congress anticipated. All I know is there were some numbers that appeared in a committee print, probably from the same people who gave you the medicare estimate in 1965 that said the program would cost $6 billion this year. I don't think anybody knew——

Mr. SHANNON. The SSA actuary.

Mr. SIMMONS. Yes, but I don't think anyone knew at that time——

Mr. SHANNON. What were the figures?

Mr. SIMMONS. I don't have them.

Mr. SHANNON. Let me give them to you. There were $5 million in 1980, $30 million in 1981, $7 million in 1982, $104 million in 1983, and $168 million in 1984. And yet——

Mr. SIMMONS. In 1984, we will do about $350 million.

Mr. SHANNON. But you budgeted for $870 million, correct?

Mr. SIMMONS. I don't follow you, sir.

Mr. SHANNON. Was your budget——

Mr. SIMMONS. I think the budget figure in 1984 was about a billion dollars, minus $100 million because of the cost of paying benefits——

Mr. SHANNON. $900 million. We projected we would save by 1984 $168 million.

Mr. SIMMONS. That is correct.

Mr. SHANNON. So this administration is projecting in its budget for this fiscal year, outyear projections, we can save five times as much from these reviews as the Congress intended.

Mr. SIMMONS. No. A couple of things you have to keep in mind. First of all, the sheer logic of it all. If you are going to review *x* number of cases, if you are going to find in that *x* number of cases 20 percent ineligibility or anything close to it over a period of time, and the program costs $18 billion a year, it stands to reason that you are talking $4 billion or $5 billion in savings by the time you get to the last year in the program. We are talking about getting up to only $1.4 billion.

Now, whether or not the social security actuaries made a mistake in 1980, maybe is not an issue. It certainly is not relevant to what is going on here. These are the same people who said in 1977 that the social security system was good for the next 50 years.

Mr. SHANNON. Have you talked to them about where they got the figures?

Mr. SIMMONS. I don't find those figures real.

Mr. SHANNON. You don't find the fact that we passed a bill in 1980 that said in 1984 this program would realize $180 million, you are going to pick up $900 million. You don't find the discrepancy relevant.

Mr. SIMMONS. Well, the Congress in 1965 passed the medicare program and said it would cost $6 billion——

Mr. **Shannon**. Both of us are here now. Isn't it true that from the first time that this administration submitted a budget in 1981, you were projecting savings as a result of these that went way beyond what anybody——

Mr. **Simmons**. That is correct. During the transition period, the GAO gave us the draft report that said 20 percent are ineligible in this program, 584,000 people, and you can probably save $2 billion a year if you could get them off.

Mr. **Shannon**. Back in 1981, when the budget was first submitted, this subcommittee sent a letter to the Secretary of Health and Human Services, Secretary Schweiker at that time. And we asked him exactly what he intended to do with this program, and what he told us in response was that he intended to go beyond what the Congress required. Now, is that what the administration has done?

Mr. **Simmons**. When you say "go beyond," you mean he was going to start it in March 1981 instead of January 1982, correct?

Mr. **Shannon**. I mean he was going to start it early, and I mean that he was going to do things that the Congress didn't require under the 1982 amendment under any circumstances.

Mr. **Simmons**. I don't follow what he would have said he was going to do that the Congress didn't intend. The Congress said review all nonpermanently disabled cases once every 3 years, begin in 1982 and end by the end of 1985. The GAO, in December 1980, said, "You ought to take all available resources you now have to look at SSI and switch them to title II because there are big dollars out there."

Mr. **Shannon**. When did you join the administration?

Mr. **Simmons**. In May 1981.

Mr. **Shannon**. Well, that was before you got there. So maybe this will be enlightening to you.

Mr. Cotter, who was on this committee at the time, inquired of the Secretary when he appeared before the committee, he said to him, "In your proposals here on page 6, you mentioned eliminating wasteful disability insurance payments by tightening administration and eliminating misdirected benefits for a total savings of $8.5 billion." And then he went on to say, "Now, in 1980, we enacted some disability benefits legislation which would eliminate many of the abuses in this area. Does your figure contemplate the savings which could be accomplished by this legislation which we enacted last year or is this something added on so to speak?"

His response was, "As I understand it, we do anticipate doing some things beyond what was done last year." And Mr. Cotter said, "There would be additional savings?" And the Secretary said, "Yes." Mr. Cotter said, "Over and above what could be accomplished by the disability amendments of 1980? Is this correct?" And the Secretary said, "That is right." And Mr. Cotter asked him, "Could you give me an indication of how you would go about this?" And the Secretary said, "These are primarily managerial controls. For example, increased screening of disability claims in cases where high monthly benefits are being paid before forwarding to State agencies the continuing investigation, and defer doing some of the SSI investigations and concentrate on the DI investigations. It is a matter of managerial function that we feel we can do internally."

What I am saying——

Mr. SIMMONS. I will tell you what that means.

Mr. SHANNON. Is the difference between what we intended this program to be and what it has become the result of these additional things that the administration has undertaken to do on its own?

Mr. SIMMONS. The Secretary was not speaking precisely—first of all, when he said the $8 billion figure—a cumulative $8.5 billion that was based on some legislative proposals we had up at the time. One had to do with the maximum benefits—the mega cap and another had to do with eligibility criteria—insured status. That one was not passed. But those had to be factored in.

[The following excerpts were subsequently received:]

With the Committee's permission, I would like to include at this point in the record excerpts from pages 238 and 239 of official hearings which show the Schweiker-Cotter colloquy to which you refer, including the material the Secretary submitted for inclusion at that point in the record.

Mr. COTTER. Mr. Chairman, I will be happy to yield to you. Thank you, Mr. Chairman.

Mr. Secretary, it is good to have you here. I want to compliment you on a fine statement, I empathize with the chairman. I, too, agree that time for study is over, and I am sure you will leave here with the impression that there is unanimity on both sides of the aisle. We have got to move and we have got to move fast on this, and I know you will cooperate with us.

In your proposals here on page 6, you mentioned eliminating wasteful disability insurance payments by tightening administration and eliminating misdirected benefits, for a total saving of $8.5 billion.

Now as you know, in 1980 we enacted some disability benefits legislation which would eliminate many of the abuses in this area. Does your figure contemplate the savings which can be accomplished by this legislation which we enacted last year, or is this something added on, so to speak?

Secretary SCHWEIKER. As I understand it, we do anticipate doing some things beyond what was done last year.

[HHS submitted the following:]

The disability insurance proposals would (a) tighten the disability eligibility requirements, (b) limit the amount of total benefits payable to social security disability beneficiaries who also receive disability benefits from other programs, and (c) intensify the review of the disability benefit rolls to assure that only those who continue to be disable remain on the rolls.

A. *Eligibility (insured status).*—Under current law a person can get disability benefits even if he has not worked under social security for as long as 5 years. To assure that only those people who can be presumed to lose earnings from covered work due to their disability can qualify for benefits, as the program originally intended, we propose to require that a person meet a recent-work test in addition to the two tests that a person must generally meet under present law in order to get disability benefits. Under the additional test, a person would need 1½ years of social security covered work in the 3-year period preceding disability.

B. *Combined benefit limitation (mega-cap).*—This proposal would assure that people who get social security disability benefits and benefits from other disability programs do not get total benefits that exceed their predisability net earnings. A person's social security disability benefits would be reduced so that the combined benefits payable under Federal, State, and local disability programs will not exceed a person's predisability earnings. The proposal would not apply to needs-based benefits, private insurance, or VA service-connected disability benefits.

C. *Continuing eligibility review.*—Additional reviews of the continuing elegibility of people getting disability benefits will help assure that only those people who continue to be disabled will receive benefits.

Mr. COTTER. This would be additional savings?

Secretary SCHWEIKER. Yes.

Mr. COTTER. Over and above what could be accomplished by the disability amendments of 1980; is this correct?

Secretary SCHWEIKER. That is right.

Mr. COTTER. Could you give me an indication of how you would go about this? You know this is a pretty tough area, particularly where it is handled on the State level.

Standards vary between States. You have administrative law judges involved in the whole thing. It is a tough area.

Secretary SCHWEIKER. These are primarily managerial controls. For example, increased screening of disability claims in cases where high monthly benefits are being paid before forwarding to the State agencies the continuing investigation and defer doing some of the SSI investigations and concentrate on the DI investigations. In other words, it is a matter of utilizing resources where we feel the biggest potential for error, fraud, or abuse is a managerial function that we feel we can do internally.

Mr. SIMMONS. When the Secretary said management controls, he meant, for example, targeting reviews on cases that are most likely to involve high risk of ineligibility. That was the profile that we used that we just announced we are no longer going to use.

Mr. SHANNON. But that wasn't required by law.

Mr. SIMMONS. No; profiling is a technique used in any review of an entitlement program. You review the cases first of those most likely——

Mr. SHANNON. Was that required by the 1980 amendments?

Mr. SIMMONS. It was required by commonsense administration of the amendments.

Mr. SHANNON. You are doing this now?

Mr. SIMMONS. No; we stopped profiling.

Mr. SHANNON. It was required by commonsense in 1981, but you just discontinued doing it; is that correct?

Mr. SIMMONS. We have discontinued doing it now for the reasons that we stated in the press conference last week and that I stated in my testimony this morning.

Mr. SHANNON. And what were those?

Mr. SIMMONS. The reasons are that it is going to relieve some of the backlog built up in the ALJ process and so that the States can have more time to focus on the toughest cases. What we were doing is something you would do in any program. What you do in any program like this is you take the cases most likely to be the ineligibles and look at them first. That is commonsense. That is why you have a category for example of permanent versus temporary.

Mr. SHANNON. You were not required to implement this. You implemented this because of commonsense. Now you have decided you will not implement it anymore.

Mr. SIMMONS. The system has become overloaded.

Mr. SHANNON. You could not anticipate that.

Mr. SIMMONS. We did not anticipate it. Just as the Congress didn't anticipate what this was going to do.

Mr. SHANNON. Let me ask you another question.

How many reviews did the Carter administration project these sorts of reviews for 1982, fiscal year 1982?

Mr. SIMMONS. I don't know if they were projected. If they were going to follow the law, they would have to do one-third of the total. And they had fewer exempted from the review than we have.

Mr. SHANNON. If I can, let me call to your attention some language when we passed that bill in 1980 that was in the report of this committee. It said:

> Your committee understands that the Social Security Administration already schedules a review in about 20 percent of new disability cases where there is a reasonable expectation that a disabled beneficiary will show medical improvement. In order to give SSA enough time to hire and to train additional staff to conduct the reviews required by this section, your committee believes that the provision should

apply to all new determinations of disability [not the whole case load] after the date of enactment and the reviews in scheduling of necessary medical examinations for all current disability cases contemplated no later than three years after the date of enactment.

That would get us to this year, 1983. When the full review of cases was to be——

Mr. SIMMONS. It was to start no later than January 1982.

Mr. SHANNON. When did you begin?

Mr. SIMMONS. We began, in direct response to a GAO recommendation in March of 1981, about 8 months early.

Mr. SHANNON. Was that required by the law?

Mr. SIMMONS. It was not required by the law, but again, it was urged on us by an arm of this Congress and it made good sense because it gave us an additional 8 or 9 months.

Mr. SHANNON. That was a discretionary decision of the administration?

Mr. SIMMONS. That is correct.

Mr. SHANNON. Isn't it true——

Mr. SIMMONS. And it was incorporated in the budget that the Congress passed in 1981.

Mr. SHANNON. Back in 1981, when we submitted questions to the Secretary, he informed us, and this is a quote from his response to us, that "We plan to increase the number of title II cases reviewed by State agencies in fiscal year 1982 by 271,000."

Mr. SIMMONS. That is correct.

Mr. SHANNON. From 199,000 to 470,000. Now, how many of these cases were in fact reviewed in fiscal year 1982?

Mr. SIMMONS. I don't know if we have that number at our fingertips. But I don't understand the line of questioning here. You have a universe of cases to do, and you have 3 years and 8 months to do them. Mathematically, we are not going to make that deadline because we have slowed the program down remarkably. But here are the numbers. Right now, for example, we are running at 25 percent below the budget level for this year. And that level was already reduced 20 percent before we even got to the 25-percent cut we just took last week. So we reduced, in effect, 40 percent of the number.

Mr. SHANNON. How many reviews were done in fiscal year 1982? Title II cases?

Mr. SIMMONS. There were 435,000 decisions made. And that includes the medical reexamination cases, the ones always done in the past.

Mr. SHANNON. So the previous administration had taken the 1980 amendments and said we can do 129,000 of these cases and you did 435,000 of them.

Mr. SIMMONS. Right, because we started the CDI review in March of 1981 instead of January of 1982. We gave the States——

Mr. SHANNON. Despite the fact that the Congress, in a report that we had submitted with the legislation said, "Go slow, allow for time to plan," despite the fact that the previous administration reviewed this and said it could do less than half the number of cases——

Mr. SIMMONS. It all depends on where you put your resources. The Congress passed a supplemental appropriation at the Carter administration's behest—putting *x* number of dollars into SSI reviews. The GAO said, "Get that money reprogramed to put it into title II." That was in December of 1980, when they told the Reagan administration transition team, "Here is how you should do this." They were incorporated in the February amendments.

Mr. SHANNON. Did you come back to the Congress and say "We want changes in the law"?

Mr. SIMMONS. I believe we sent letters up to get some reprogramed money. And the Congress gave it to us.

Mr. SHANNON. Did you come back to us and say to this committee, "We want some changes"?

Mr. SIMMONS. You don't need a change in the law to carry out the law. The question is when do you start. The Congress said, "Start no later than January of 1982."

Mr. SHANNON. Isn't the point that you went a lot further than you were required to under the law?

Mr. SIMMONS. No, sir. It is not.

Mr. SHANNON. Well, how many reviews were you required to do under the 1980 amendments?

Mr. SIMMONS. In that year? Depending on when you started the 3-year cycle, you had to do——

Mr. SHANNON. Did the Congress say you have to review 430,000 cases in fiscal year 1982?

Mr. SIMMONS. No, sir.

Mr. SHANNON. How many did you review?

Mr. SIMMONS. 435,000.

Mr. SHANNON. That, it seems to me, is the point. In your testimony, you try to indicate that this is something that you were required to do by the 1980 amendments.

Mr. SIMMONS. We are required to do it by the 1980 amendments in a 3-year span. We elected to lengthen the span in order to spread the workload out more. We gave the States 66 percent more money and 30 percent more staff.

Mr. SHANNON. You did twice the number of reviews, at least twice the number you were required to do in fiscal year 1982, but that is lengthening out the time of implementation? How is that?

Mr. SIMMONS. Well, I will repeat it. We did nothing that was against the law. We did nothing that was against commonsense in administering the law.

Mr. SHANNON. But you have already discountinued one of those proposals that you put into place in the name of commonsense.

Mr. SIMMONS. One of those proposals has been discontinued—one of the administrative actions has been suspended.

Mr. SHANNON. What made it sensible to do that in 1981 but——

Mr. SIMMONS. I don't think you would find a social service administrator anywhere in this country who would not tell you that that was a wise thing to do.

Mr. SHANNON. Now, at the time——

Chairman PICKLE. I wonder if—how much longer does the gentleman want to pursue this line of questioning?

Mr. SHANNON. A few more minutes.

Chairman PICKLE. Proceed. Let me interrupt you just a minute. Mr. Simmons, why did you start in March 1981?

Mr. SIMMONS. That was in direct response to the GAO urging that we do so. The GAO gave us a report which said that now that we have validated the kinds of numbers we are talking about, that there may be 584,000 people on these rolls who are ineligible, you may be spending $2 billion a year in recoverable benefits, you ought to take all your——

Chairman PICKLE. The reason you started in March of 1981 was because GAO suggested it, and I presume for saving money.

Mr. SIMMONS. That is right. It was incorporated into the budget amendments. They were passed by the Congress.

Chairman PICKLE. If the GAO had not recommended it, you would not have done it?

Mr. SIMMONS. I am sorry?

Chairman PICKLE. If the GAO had not recommended it, you would not have done it?

Mr. SIMMONS. Probably not. Although we might have, because when we looked at the numbers coming into office, and when we looked at the state of the social security trust funds at that time, it just didn't make any sense. That was about 40 percent of the daily deficit running in that program.

Chairman PICKLE. Was the hot breath of the OMB involved in this at all?

Mr. SIMMONS. The hot breath of budgeteers is, in general, in all Government decisions, I think. But in terms of starting early—another point about that is that it gives you 8 more months than you would have had if you did it on a 36-month cycle. Even with that added time we will not make it.

Chairman PICKLE. Now, Mr. Shannon.

Mr. SHANNON. Thank you, Mr. Chairman.

Let me ask you, does SSA always do what GAO suggests if you have the power to do it?

Mr. SIMMONS. Whenever they suggest something that is reasonable, rational, intelligent, farsighted, and full of wisdom, we do.

Mr. SHANNON. And I suppose you have your own criteria for seeing whether or not something is reasonable and rational?

Mr. SIMMONS. We publish those in regulations.

Mr. SHANNON. It tends to mitigate heavily against disabled and retired according to my experience in watching this administration.

Mr. SIMMONS. When we took office there were 675,000 people exempted from the review by the Carter administration definitions. There are now a million. We have increased that by almost a half a million people. We have exempted 40 percent from this review altogether. One of the reasons, probably, that the Carter administration did not exempt as many as we have, is they had no management information system built into this program. When we came into office, and tried to determine what was out there in terms of what kind of cases there are, we discovered you cannot even punch that up on the computer. You have to go manually through the cases.

That kind of thing is being fixed now, so we can administer the program better and identify the people who shouldn't be reviewed at all. That is what we have done in increasing that exemption to a million. As I pointed out, the entry statistics coming into the program now are going back up after almost a 50-percent drop in the 4 years before we took office. So I don't think you can say we have set out to do anything consciously.

Mr. **Shannon**. You did consciously decide to review more cases than required by the law. You projected a lot more in savings from these reviews than the administration or the SSA had projected before this administration took office.

Mr. **Simmons**. I am not going to make amends for people doing arithmetic in whatever month that was in 1980. It stands to reason if you have anything approaching a 20-percent ineligibility rate and an $18 billion program and you remove the ineligibles you are talking $4 billion a year.

Mr. **Shannon**. Where did you get the 20-percent figure?

Mr. **Simmons**. From the GAO report based on our standards.

Mr. **Shannon**. Here you are, top administrator, and you are willing to dismiss as being totally ridiculous numbers developed by your own actuary at a time when you are willing to embrace numbers thrown at you by GAO? I don't understand that.

Mr. **Simmons**. I am not dismissing them as totally irrelevant. I am saying for purposes of this argument that if you have a system that costs $18 billion and has *x* percentage of a problem in it——

Mr. **Shannon**. Where did you get that percentage?

Mr. **Simmons**. That came from a very big study that we did ourselves and which the GAO looked at and said that it was good work.

Mr. **Shannon**. But you took your actuary figures, and said we are not going to pay any attention to them, and you took GAO's figures and said we can save a lot more money if we adopt these figures and we will base our planning on these figures. And for the very first——

Mr. **Simmons**. Those figures were developed by the Social Security Administration.

Mr. **Shannon**. From the very beginning of this administration you have gone beyond what was required by the law and projected savings way beyond what anybody thought you could save from the review of these cases. And you wonder why there is a problem.

Mr. Chairman, I want to ask unanimous consent that a study which has been done by the Congressional Research Service, which I requested, on the administration's role in the periodic review of disability cases be submitted and entered into the record. I think that this report, which goes through the history, which goes through the testimony, which goes through the legislative requirements really sets out where this problem lies.

And it lies, I think we will all conclude from reading this, not here in the Congress, but in the OMB and in the highest levels of the administration.

Chairman **Pickle**. That study will be included.

It will be included in the record.

[The material referred to follows:]

Congressional Research Service,
The Library of Congress,
Washington, D.C., June 22, 1983.

To: Honorable James M. Shannon.

From: David Koitz, Specialist in Social Legislation, Education and Public Welfare Division.

Subject: Administration's Role in the Periodic Review of Disability Cases.

This is in response to your inquiry to me about the nature of the current Administration's role in the implementation of the new periodic review procedure in the social security disability insurance (DI) program. Specifically, you asked if, and to what extent the Reagan Administration expanded upon the "periodic review" provision of the 1980 Disability Amendments, and whether that expansion may have exceeded the expectations of Congress, and in particular, the Committee on Ways and Means. My response treats this inquiry as two separate questions.

1. EXPANSION OF THE PERIODIC REVIEW PROVISION BY THE ADMINISTRATION

To begin with, you are correct in your recollection that expanded use of section 311 of the Social Security Disability Amendments of 1980 (periodic review of disability determinations) was one of a number of initiatives taken by the Administration as part of its Fiscal Year 1982 Budget reduction package. It was first announced on February 18, 1981 when the White House released a document entitled "A Program for Economic Recovery." Three areas in the social security cash benefits program were identified for budget reductions in that document, one of them containing three initiatives to tighten eligibility in the DI program. The first was an administrative effort to be carried out under existing law. This consisted primarily of an effort to "intensively review" the existing DI caseload. The document stated:

> The Administration will reduce rapidly growing disability insurance costs by tightening administration and ending misdirected benefits. A new management team will take action to eliminate ineligible payments.
>
> Social Security Administration (SSA) studies confirm that huge sums are paid incorrectly to individuals misclassified as disabled. As a result, DI caseloads have risen by 80 percent since 1970, and costs have climbed by 500 percent. Under the direction of this Administration, the SSA will begin to intensively review cases to insure that only the truly disabled receive disability benefits.[1]

This document included estimates of $3.450 billion in savings for the period from Fiscal Year 1981 to Fiscal Year 1986 to arise from improved management of the program. These were to be savings over and above those previously estimated to arise from the administrative provisions of the 1980 Amendments.

The nature of the new initiative as an expanded use of the 1980 provision was elicited from then Secretary Schweiker in an exchange with former Representative Cotter when the Secretary testified on February 17, 1981 before Subcommittee on Social Security of the Committee on Ways and Means. The Secretary emphasized that substantial program savings over and above those contemplated in 1980 were assumed to arise from better management control of the program. A portion of that exchange follows:

> Mr. Cotter: In your proposals here on page 6, you mentioned eliminating wasteful disability insurance payments by tightening administration and eliminating misdirected benefits, for a total savings of $8.5 billion.
>
> Now as you know, in 1980 we enacted some disability benefits legislation which would eliminate many of the abuses in this area. Does your figure contemplate the savings which can be accomplished by this legislation which we enacted last year, or is this something added on, so to speak?
>
> Secretary Schweiker. As I understand it, we do anticipate doing some things beyond what was done last year. . .
>
> Mr. Cotter. This would be additional savings?
>
> Secretary Schweiker. Yes.
>
> Mr. Cotter. Over and above what could be accomplished by the disability amendments of 1980; is this correct?
>
> Secretary schweiker. That is right.
>
> Mr. Cotter. Could you give me an indication of how you would go about this? You know that is a pretty tough area, particularly where it is handled on the State level.

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[1] The White House, "America's New Beginning: A Program for Economic Recovery," Feb. 18, 1982.

Standards vary between States. You have administrative law judges involved in the whole thing. It is a tough area.

Secretary Schweiker. These are primarily managerial controls. For example, increased screening of disability claims in cases where high monthly benefits are being paid before forwarding to the State agencies the continuing investigation, and derfer doing some of the SSI investigations and concentrate on the DI investigations. In other words, it is a matter of utilizing resources where we feel the biggest potential for error, fraud, or abuse is a managerial function that we feel we can do internally.

Mr. Cotter. There is no question there are many abuses in this area, but would it be done by your Department, or what is the mechanism you contemplate?

Mr. Schweiker. Yes, it would be primarily done within our Department, and would be a matter of reassigning some priority, instead of sort of treating everything the same across the board. We would look where the biggest potential for abuse might be, and investigate these areas as opposed to just at random doing some things that we have sone in the past. . .[2]

Finally, more detail on the magnitude of the new management initiative was provided to the Subcommittee in an April 17, 1981 letter from the Secretary, who was responding to written questions posed by Chairman Pickle. The response emphasized the administrative nature of the expansion of periodic review as part of President Reagan's Fiscal Year 1982 budget program. It pointed out that some $200 million in savings were expected to arise in fiscal year 1982 from the accelerated Continuing Disability Investigations (CDI) effort over and above those estimated in the Carter Administration's budget. The Carter budget anticipated only $4 million in savings for fiscal year 1982 from implementation of periodic review. The following excerpts from the Secretary's response also point out the expected differences in the number of reviews to be conducted.

Question. We understand that funds have been budgeted for an additional 310,000 Continuing Disability Investigations (CDI) for fiscal year 1982. Were the savings for possible terminations incorporated into the Carter budget or are they part of $200 million additional savings in the Reagan Budget Proposal?

Answer. The Carter budget contained funds for an additional 310,000 Continuing Disability Investigations in fiscal year 1982. Of this total, 240,000 were expected to receive a medical reevaluation in the State agencies.

The additional CDI's were budgeted to result from the following activities:

210,000—implementation of the periodic review provision of Public Law 96-265.

100,000—review of current SSI beneficiaries who were "grandfathered" into the Federal disability program from the State programs, in January 1974, to assure that they continue to meet the definition of disability.

The savings from expected terminations as a result of the 310,000 CDI's were incorporated into the Carter budget. . .

President Reagan's budget for fiscal year 1982 provides for $200 million in additional savings. [See response to last question on page 5 for the number of additional reviews.]

Question. Will you require any additional legislative authority to carry this out?

Answer. Through the President's plan of tightening the administration of the social security disability program, we anticipate a savings of $200 million, in addition to the savings already estimated for the reexamination called for by the 1980 disability amendments. No additional legislative authority will be required to carry out this plan.

Question. Precisely what measures will be taken to remove ineligibles from the rolls and how will they differ from what is contemplated under existing law?

Answer. Essentially, there are two basic activities we plan to undertake to achieve the projected savings. First, there will be an acceleration of the CDI processing schedule. Beginning in March 1981 we have implemented a plan to target high risk cases and process them as additional CDI's. The prior plan has assumed that we would begin processing the additional CDI's on the January 1982 starting date of the periodic review provision of the 1980 disability amendments. Second, we plan on shifting budgeted resources from SSI CDI's to the higher-payoff title II cases (title II average benefits are higher than SSI average benefits).

Question. What are the assumptions and savings projections for the preffectuation review and periodic reexamination required by Public Law 96-265?

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[2] U.S. Congress. House. Committee on Ways and Means, Subcommittee on Social Security. Hearings on Social Security Financing Issues, Feb. 17—Mar. 23, 1981. Washington, U.S. Govt. Print. Off., 1981. Serial 97-3, p. 238-239.

Answer. [Unrelated portion omitted]. . . By January 1982, we will be processing approximately 30,000 additional medical CDI's per month under the mandate of the periodic review provision of Public Law 96-265.

The projected fiscal year 1982 savings of all these activities are as follows:

	Millions
Preeffectuation review	$18
Periodic review	4
Accelerated CDI processing (Reagan initiative)	200
Total 1982 savings	222

[Unrelated portion omitted] . . . We believe that 20 percent or more of the current beneficiaries may not be disabled and, therefore, not entitled to disability insurance benefits. SSA is accelerating the administrative process (continuing disability investigations) under which beneficiaries with the potential for recovery are reviewed to determine if they are still disabled. We plan to increase the number of title II cases reviewed by State agencies over the level proposed in the Carter budget in fiscal year 1981 by 135,000 (from 139,000 to 274,000). We plan to increase the number of title II cases reviewed by State agencies in fiscal year 1982 by 271,000 (from 199,000 to 470,000).[3]

EXPECTATION OF THE CONGRESS ABOUT THE IMPACT OF PERIODIC REVIEW

While it is fairly clear, that at least initially, the Administration perceived their implementation of section 311 as going substantially beyond what Congress in enacting the provision in 1980 had reason to believe the provision would accomplish, you specifically asked what exactly were the expectations of the Congress, in particular those of the Committee on Ways and Means, in 1980 when periodic review was enacted.

It should be recognized first that there has been little question about whether the Administration had the legal authority to intensify its efforts to screen the disability rolls. Section 311 of the 1980 Amendments was not necessary for that or any other expansion. Authority to review eligibility has existed since the beginning of the program. Section 311 merely imposed a "minimum" review requirement upon the administrators of the program. However, what is not really clear from the legislative history is how Congress expected section 311 to be implemented and what it expected its impact to be.

The language of the provision itself basically called for a review of all beneficiaries, whose disabling conditions were not permanent, at least once every three years. Beneficiaries diagnosed as having permanent impairments were to be reviewed under a less frequent schedule to be determined by the Secretary of Health and Human Services. The minimum review requirement was to be implemented beginning in January 1982. Whether or not there was to be an immediate "cleansing of the rolls" or alternatively a slower transitional approach was not specifically spelled out in the legislation itself.

A literal reading of the language might imply that the "cleansing" approach was required. It might imply, for instance, that in the first year of implementation, one third of those persons on the rolls, who were not permanently disabled, had to be reviewed within that year. This, however, is not a definitive statement about what Congress intended or expected.

First, there is a statement in the report of the Committee on Ways and Means to the House on the 1980 Admendments which suggests that the Committee possibly expected a phased approach would be taken to implementation of the provision. The Committee report suggests that there was concern about the administrative impact the provision would have on SSA. The statement follows:

> Your committee understands that the Social Security Administration already schedules a review in about 20 percent of new disability cases (where there is a reasonable expectation that a disabled beneficiary will show medical improvement). In order to give SSA enough time to hire and train additional staff to conduct the reviews required by this section, your committee believes that the provision should apply to all new determinations of disability after the date of enactment and that reviews and scheduling of necessary medical examinations for all current disability cases be completed no later than 3 years after the date of enactment.[4]

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[3] Ibid., p. 227-229

[4] U.S. Congress. House. Committee on Ways and Means. Report on the Disability Insurance of 1979. House Report No. 96-100. Washington. U.S. Govt. Print. Off., 1979. 96th Congress, first sess. p. 10.

Secondly, the cost estimates prepared at that time do not suggest that much of an impact was expected from the provision. The cumulative benefit savings estimated by SSA for the first five years after enactment only amounted to about $300 to $400 million. The Congressional Budget Office (CBO) estimates were not greatly different. Furthermore, both sets of projections showed that in the first few years after the enactment, the administrative costs would actually exceed the benefit savings.

In addition, the financial impact report given by CBO both to the House Ways and Means and Senate Finance Committees stressed the uncertain impact of the provision, suggesting that it was even possible that there might be no savings from the new provision, since the provision possibly would cause the agency to only formalize what it was then doing in the area. In summary, both the Office of the Actuary and CBO showed a financial impact which was much lower than the projected savings of $4.9 billion recently given to the Senate Special Committee on Aging by the Administration for the period 1982 to 1986.[5]

Thirdly, it should be recognized that the Congress in 1980 was not reacting to evidence that there were a large number of ineligibles on the benefit rolls. There was no quality assurance data or studies indicating a 20 percent ineligibility rate provided to the Committees during hearings or mark up sessions on the bill. The periodic review provision was merely a reaction to the apparent inattention of the Social Security Administration to reviewing the rolls which was indicated by the fact that the number of persons reviewed each year stayed at about 150,000 to 200,000 through the 1970s even though the rolls grew rather significantly during the period.

Finally, neither the language of the provision nor the reports of the Committees gives any guidance to the program administrators as to how the provision was to be implemented. No details were given on what constituted a "permanent" impairment and no direction was given as to how to go about conducting the periodic reviews. For instance, was the agency supposed to conduct a medical re-examination of only a limited number of persons or of all persons subjected to the review? Could they set up a simple paper review at the Federal level to screen out most of the cases from a State agency investigation, or did most cases actually have to be examined by the State agencies? Could they use recovery-prone and error-prone case profiles or were they to review cases randomly?

It is probably this latter lack of specificity in the legislative history—about how the new review process was to work—which creates the greatest amount of uncertainty about the then "congressional expectations," while simultaneously giving substantial discretion to the administrators of the program about how the provision was to be implemented.

Chairman PICKLE. Mr. Anthony.

Mr. ANTHONY. Thank you, Mr. Chairman.

I have an equal number of questions I would like to ask.

However, it upsets me to think that this is one of the arguments that no one can win. Mr. Shannon can get mad and hostile at the administration and Mr. Simmons, representing the administration, can get hostile and mad at Mr. Shannon. But the truth of the matter is that Congress did mandate something.

But we ended up with a problem on our hands and the administration was astute enough to realize it was a political problem. As a result, the administration issued some corrective positions of which I applaud them for.

It concerns me to think what we may have to do in the future to try and resolve the problem. But looking back in history on our previous mistakes may help us learn to deal with the problems we are presently faced with. I now have a very simple question to ask.

At any time during the discussion of whether or not to implement a certain number of disability review cases, was a consideration given as to whether or not the State agencies could in fact handle the volume.

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[5] Based on a written response to questions from the Senate Special Committee on Aging asked at an oversight hearing on evaluation of mental impairments, Apr. 8, 1983.

Mr. SIMMONS. Yes. Very much so. We provided over 66 percent more money to them and over 30 percent more in staff. We made that available to them. Some States could not staff up. Some Governors have State employee hiring freezes and will not brook any exception, even when it is a fully federally funded program like this, because it makes their body count look bad in their budget, at a time when many Governors are laying off State workers in order to cut back because of the general economic problems. In those States, we have slowed the casework down very much—17 States, for example, at any one time last year were under a suspension of any cases coming in.

Mr. ANTHONY. Was Arkansas one of those?

Mr. SIMMONS. I do not know, sir.

Mr. ANTHONY. I would like to ask you to take a close look at what occurred in the State of Arkansas. In 1981 we had a staff of 11 to handle the Arkansas continuing disability investigations for approximately 2,100 cases. In October 1982, we had increased that staff from 20 to 32 for a 281-percent increase in staff.

And we have a Governor who was willing to accept criticism for adding staff up to 281 percent because he knew there was a need for the increase in staff.

But the truth of the matter is those people had to review 9,800 cases which is a 470-percent increase. So although they had an increase in personnel, they had a tremendous increase in caseload, and as a result they even fell further behind.

Mr. SIMMONS. The Arkansas DDS I am told is one of the best in the country in terms of processing cases, speed, accuracy, et cetera. They have been very cooperative with us on consulting groups we have had in made up of State administrators to help us get this thing running as smoothly as we can.

But I think that in looking at the increase in the staffing versus the increase in the caseload, you have to keep in mind most of the increase in staffing you put on when you expand an effort like this are the professionals who do the review and not the clericals. That is why I say a one-third increase in staff is primarily the claims examiner, people trained to do this kind of thing.

The workload figures used in budgeting for all these are the same ones they have used for years and years and years in this program. It is a workload-driven program. You have *x* number of things to do; *x* number of people to do it. We made the money available to the States. Some States could not use the money. Almost all now are. Four or five still have a problem.

Mr. ANTHONY. I am especially proud of the fact you have said such nice things about our disability program in Arkansas because we are proud of it. We think we have done a vast amount of good work with such a small budget. We have a high elderly rate and as a result of that, we have also had a lot of terminations, without what we consider to be full medical evaluations.

As a result, political pressure has built greatly not only on our Governor, who was forced to come here, but also on the Members of Congress.

This leads me to my second question: What is the possibility of doing a full evaluation to determine whether or not a recipient is able to work?

The truth of the matter is that the law and the regulations are on your side. But equity may not be on your side as Mr. Jenkins eloquently pointed out. And I represent a rural area much like that of Mr. Jenkins. I would have to hunt really hard to find the elevators and parking lots. I think it probably brings us back to that central point. What is the feasibility of allowing these people a full medical evaluation to determine if they can work?

That is what my constituents want. They want these persons who are able to be working to be taken off disability so that those that are unable to work may be helped.

Mr. SIMMONS. You have hit on two of the issues that are really at issue here and that we have talked about this morning, and we are certainly looking at with our outside experts. One of them is the issue of medical improvement as a principle. As I said in my testimony, and as I said in answer to questions, we are very seriously looking at the issues around that and we do think that ultimately it will have to be addressed in the law.

It is a very difficult principle, and you don't want to take the risk that it goes too far in one direction or the other. So something has to be clear in the law.

Second, what do you do with a person who is quite disabled but not totally disabled in the eyes of the law but has been on the rolls for some time—which in itself may be a disabling condition? If a person came on the rolls in 1975 and was never told that he might be reviewed again and suddenly in 1982 or 1983 he gets a letter saying your case is under review, those people in their own minds have been retired, they are retired from the work force.

They have not been in the work force. The jobs they used to do may not even exist anymore. And the program now looks, as it always has, at the law and says, "are you or are you not disabled?" What does that mean? It means you cannot do anything anymore.

Mr. ANTHONY. Let me go to the third point. And that is how serious are you about making this evaluation review?

Mr. SIMMONS. We are very serious.

Mr. ANTHONY. Let me tell you about the complicating factor that I would be caught in if I were to return to Arkansas to practice law.

For example, if a disability case came into my office, and I thought I could generate the proper medical evidence for it, I would take it through the review process and hopefully win. Then I must take that case on again if the person is caught up within the periodic review and being terminated. I would go through the appellate process, and read all of the court decisions within my jurisdiction. And I would obviously see what the U.S. circuit court of appeals had ruled.

Well, I would not care what your regulations said because I would be in a court of law. The Eighth Circuit Court of Appeals in three separate cases, 1982, *Simpson* v. *Schweicker,* in which Arkansas was covered, does say that the Secretary may not terminate benefits without substantial current evidence about a claim since the previous finding of disability.

SSA, however, continues to insist that it will make a de novo decision as to whether or not a person is disabled based on its new guidelines and without regard to its previous findings.

So I must confront my client and explain to him that the law is one thing in my jurisdiction, and the guidelines from the regulatory agency in Washington is another. Maybe this is a subject that Mr. Gonya should properly address.

As a practicing attorney before I came to Congress, and one that probably will practice after I leave Congress, and knowing that there are other conflicts within other circuits, I think that this is one of the more serious technical problems that we are faced with.

I would like to be assured that you are willing to take the court decisions under serious consideration, so that we can obtain a national standard rather than 11 different standards.

Mr. SIMMONS. That is what we are after—a national standard. And that particular issue probably will have to be clarified in the law or in committee language or somewhere where there is a set policy that is agreed upon by the executive and legislative branches. Otherwise, you are going to get a patchwork of decisions around the country.

It is inevitable in any program. Food stamps, AFDC, any entitlement program gets caught up in the same thing.

What do you do when you have conflicting decisions in this part of the country but the case is so murky that, even if the court would accept it, it might not clarify the issue?

Mr. GONYA. If I might add to that. I understand very well, Mr. Anthony, the dilemma you describe as a practicing attorney. But on the other side, I think it must be recognized the dilemma that the Social Security Administration is in when the Congress has told them when enacting the SSI program that it wanted the SSI program administered on a national basis. Again, as recently as in the 1980 amendments the Congress chose to expressly, specifically put into law that the degree of disability will be determined under national uniform standards.

Mr. ANTHONY. Would you yield for an inquiry?

Mr. GONYA. Surely.

Mr. ANTHONY. Would you consider the Tax Code as being one that should have national implications? And adjudicated on a national basis? It is my understanding that the Internal Revenue Service does acquiesce to circuit court of appeals decisions. What you are saying is that one agency of the bureaucracy will abide by it, and another agency won't. Both of them should have the same standards because we are all American citizens.

So, personally, I think your argument is about as faulty as a sieve.

Mr. GONYA. But it is also my understanding that the IRS is an agency that issues rulings of nonacquiescence.

Mr. ANTHONY. If I——

Mr. GONYA. I might add that those cases have been to the Supreme Court, and the Supreme Court has never held that an IRS ruling of nonacquiescence was invalid, nor did they ever even criticize it.

Mr. ANTHONY. We are not going to win that legal argument. Just like Mr. Shannon is not going to win the political argument right here. That argument is going to be decided at the ballot box in November 1984.

What we are trying to do is at least speak for our constituencies, to make you keenly aware of the conflicts within which we have to operate in hopes that you would take these viewpoints into consideration and would try to resolve them.

I must tell you at the outset that I publicly spoke up and told the people in my district that I thought the disability rolls were swelling unnecessarily, and that I was willing to try and stop it. I even voted previously to try to do what we are doing now. And I am certainly going to vote to try and bring some fairness and equity into what we are trying to do.

I just have one final request.

Mr. Chairman, this goes back to the inquiry that you made to the panel awhile ago. I guess this would be directed to Ms. Owens.

As I understand it, in response to those cases within the pipeline, on functionally psychotic individuals, that if I have a client and am in the reviewing process, and the Secretary's ruling of June 7 or 8 did not pertain to my case—then I must fight the bureaucratic appellate process. Yet, if the lawyer across the street had a case that he was getting ready to go into court with, and just happened not to have it there until after that date, he can go to the coffee shop and tell his client he has won temporarily; I have to tell my client, that, I am still in the appellate process. I am going to tell you what. That stinks.

Ms. OWENS. Could I just——

Mr. ANTHONY. If I were you, what I would do is take all the cases that fall within that category, wherever they are within the appellate process, and write them a letter and pull their file and put it in the suspended file until Congress resolves this issue.

Then you have truly done equity to everybody within that category.

That is a request, not even a question—just a simple request.

Ms. OWENS. OK.

Mr. ANTHONY. I would like to be able to go home and argue some fairness for you.

Chairman PICKLE. I thank you, Mr. Anthony. I assume——

Mr. ANTHONY. I apologize for the length of the questioning, Mr. Chairman.

Chairman PICKLE. Not at all.

Incidentally, Mr. Secretary, we are going to submit to you a raft of questions. We want responses from you. We would like to have them almost immediately, within 1 week's time, because we hope when we come back from recess, we can start looking at this concretely and quickly. The October date is coming.

Now, I have got one or two questions. I want to talk to you face-to-face here.

Let me ask Secretary Cohen—are the witnesses willing to work through the lunch period?

Mr. COHEN. Yes. We do have a 2 o'clock appointment, however.

Chairman PICKLE. We will do this. I want to tell you—can you wait until we answer this rollcall and then come back. Then we have two or three other questions.

We appreciate your willingness, Mr. Secretary, you and the other gentlemen—former Secretary of HEW Wilbur Cohen is here, who helped to write all these laws. I have never seen him be quieter and less talkative in my life.

Mr. COHEN. Wait until you hear me.

Chairman PICKLE. We appreciate your cooperation.

We find you very important to get this information.

The Chair is going to stand in recess for 10 minutes.

[Recess.]

Chairman PICKLE. We will ask the subcommittee to come to order. We will resume our considerations.

Now, Mr. Secretary, I think we made some progress on the question of medical improvement. I hope we have, and that we are looking for some approach that might be an improvement on the present procedures.

I thought your testimony was helpful in that area. I thank you for it.

Now the question of face-to-face hearings. That you may repeat, at—we all agree we ought to have face-to-face hearings. And that is going to be implemented. I think it will be very helpful.

At what level do you think the face-to-face hearings should take place?

Mr. SIMMONS. Could I ask Mr. Hays to answer that. He has all the details on it.

Chairman PICKLE. Mr. Hays. We will be glad to hear from you.

Mr. HAYS. It is our opinion, Mr. Chairman, that the face-to-face—the first face-to-face hearing should be at what is currently referred to as the reconsideration level. In other words, the very first step of the appeals process is where we believe the first face-to-face contact should be between the individual and the decision-maker.

Chairman PICKLE. You have no difficulty in changing it from the ALJ level to move it up earlier. It is your recommendation that the recon level would be——

Mr. HAYS. That has been our position for a considerable period of time, yes.

Chairman PICKLE. If we moved it up to the reconsideration level, or the State level, would the States be able to have the personnel and be able to handle the cases?

Mr. HAYS. Well, under the process that we are prepared to implement no later than January 1, the process would be a combination State agency effort and Federal effort.

Chairman PICKLE. How would that work?

Mr. HAYS. The State agency disability examiners would, as they do today, develop the medical evidence for those cases which are going into this new reconsideration process, Then, once a case was developed, it would go before a Federal hearing officer who would come face to face with the individual claimant and make the decision. Unless the State agency decided during the course of doing its development that in fact that case should have been paid, in which case the State would in fact pay the case and it would not have to go on to a hearing.

Chairman PICKLE. At the reconsideration level.

Mr. HAYS. Yes; that is correct.

Chairman PICKLE. My question is—does this pose a problem for the State? Can they do it?

Mr. HAYS. We think this is the best—this represents the least impact, the least disruptive impact——

Chairman PICKLE. Have you asked the States whether they can do it? Do you have a policy made of the States?

Mr. HAYS. We have worked closely with the States. In fact, we have an advisory group of State agency directors assisting us in this project. I think they would all say to the extent that any additional State agency personnel might be required to participate in this new project, this new process, that they would of course want to have advance funding for that as part of the budget process, and the budget process would in fact allow to the extent that the States require additional people, to have those additional people.

But it would be minimal—because we would in effect be using the same State agency personnel who are currently involved in the existing State agency reconsideration process. It would have a minimal impact on their resource situation.

Chairman PICKLE. I am trying to find out, Mr. Hays, in your opinion, can the States handle it if we can move the face-to-face up to the reconsideration level? Can they handle it?

Mr. HAYS. Under our process whereby they would do the development work and the Federal employee would do the hearing, the answer would be yes.

Chairman PICKLE. As far as you know, the States have not protested this possible change of procedure?

Mr. HAYS. Some States have protested in the sense that some States say that they would like to have the right of first refusal, if you will. They would like to have the option of saying, yes, we will do it or, no, we will not do it.

A few States have specifically——

Chairman PICKLE. The choice to do it at that level or at some other level?

Mr. HAYS. Just the option of saying yes or no: Yes, we will take it; no, we won't do it.

Chairman PICKLE. I don't think we should expect you to have 100 percent. But in the majority of cases, you feel that the States could do it because of present personnel and because the procedure would be such that they could handle it.

If we did it at that level, there would be no problem with the States?

Mr. HAYS. If the State were to conduct the actual to face-to-face part, the hearings themselves, then I believe there would be a serious problem with meeting the implementation date of the law, which is January 1.

We have planned for implementation in which the hearing itself would be conducted by a Federal employee, with the preparation, the work being done prior to the hearing by the State agency. Under that scenario, we have no problem meeting the required date.

Chairman PICKLE. Suppose we move it up to the reconsideration level and suppose that we—then we were going to have the cases heard at that point by State people instead of Federal people.

What is your feeling on that regard?

Mr. HAYS. The first problem, Mr. Chairman, is that in fact it is our belief that not every State would be able to do this, not every

State prefers to do it themselves, and not every State in fact would have the capacity of doing it themselves.

Chairman **Pickle**. That is true of your previous position.

Mr. **Hays**. One of the major problems with that proposal is that we would end up with a situation where in some States it would be done by State people and in other States it would have to be done by Federal people, and therefore you are faced with the possibilty of a situation which would result in lack of uniformity and uneven results.

Chairman **Pickle**. If we had the law read that it would be done by State people, it wouldn't be done one way in one State and in one State another.

Mr. **Hays**. If it were mandated.

Chairman **Pickle**. What is the best way of handling it, through the Federal people at the reconsideration level or whatever level or by State people?

Our committee has been presented positions and we will hear some of them today about what will be better. Initially the Federal people would be more professional and more knowledgeable in it perhaps. But they are concerned that they would become professionals.

It might be better to have people at the State level. Various groups have changed their position on that. The Congress may have to decide who will perform these services.

You are saying it ought to be the Federal people, and I am saying there is two sides to that.

Mr. **Hays**. We would say that given what we think are going to be the very desirable results of this new process we would hate to see implementation delayed. Perhaps there is a middle ground where we could proceed to implement by January 1 under the way in which I have described with Federal hearing officers and the State agencies doing the development work, and then at some point when there is more time, perhaps then allow for some conversion to the State option.

Chairman **Pickle**. I understand your position is that at the initial stage the State people would help prepare the case, and then the face-to-face would not be held until the reconsideration level?

Mr. **Hays**. Yes.

Chairman **Pickle**. What about this: Suppose we were to just have this eye-to-eye testimony, face to face at the initial stage, right at the beginning, up front. When he comes in, he says, "I am disabled," and we will say, "produce your evidence."

Mr. **Hays**. And as part of that, do away with the reconsideration process entirely?

Chairman **Pickle**. I guess my position is, what do you think about taking that route and just doing away with the reconsideration level?

Mr. **Hays**. It would have two troubling results. One is that it would be extremely difficult and have enormous resource implications to provide a face-to-face contact for all applicants at the initial level before the State agency. Keeping in mind that many State agencies are centralized—they do not have facilities throughout the State—they would have to hire more people and obtain more facilities, and that would be a very difficult thing for the State to do.

By doing away with the reconsideration process, even if there was a significant increase in the number of people allowed at that initial level as a result of that face-to-face contact, there would still be an increase in the number of appeals going to the administrative law judge level. If you think we have a backlog now; it would be nothing compared to what that would produce.

Mr. SIMMONS. This program has a very high nonallowance rate up front. It runs around the 70-percent range.

Part of that reason is because a lot of people apply to the system just to take a run at it and see if they can get on. In a lot of States, for example, when you apply to a State welfare program, they say "first you have to go to Social Security and apply for disability."

If you were to take your face-to-face resources and channel them to the front, half the time they would be wasting their time because a person has no chance of getting on the system. But if you have to devote the resources to doing that, it doesn't make sense from an administrative point of view to have that face-to-face up front.

Chairman PICKLE. I think we agree that we ought to have the face-to-face moved up earlier to the earliest practicable workable date, whether at the initial level or at the reconsideration level, it ought to be done.

I assume from your testimony that the pilot program you have run proves that they have a better determination that holds up better than under the present procedure if you do have it at the reconsideration level.

The present level now is—have you done this at the initial level or at the reconsideration level?

Mr. HAYS. This was done at the reconsideration level just as required by Public Law 97-455, and you are right, the pilot tests were very encouraging.

The allowance rate for the cases that went through the pilot projects was about 38 percent, and that means that there were a significant number of people who didn't have to wait another 180 days or so to go all the way up to the administrative law judge level.

Chairman PICKLE. I have a feeling that if everybody in America who would be a possible claimant for disability knew that they were to make their case at the beginning at the most practical initial point, I think we would have the facts up front and could probably make a better decision. So whether we go the initial stage or the reconsideration stage, that is something for the Congress to decide.

If you have any specific recommendation, I would like to have it. You tell me we would have a problem, which means that maybe you would and maybe you wouldn't. If you have a considered recommendation, let us have it, if you will.

I am concerned about one or two other factors.

I want to recognize Mr. Cohen and Mr. Driver.

We have had some complaints from some of the other members that even after favorable determination has been made on disability cases, that the claimant does not get a check. In many cases for 2, 3, 4, 5 months, checks not being issued.

I have three or four different examples of members that have written to our subcommittee.

Is this a problem? Is it a major problem?

When we get it over and over, three or four times, then we think it is a serious problem.

Mr. SIMMONS. Part of it is the system. In order to counter it, we have set up a special unit to handle cases that come back out of the ALJ process.

It was a function of the inability of the computers to handle the kind of load and the way it came through. It is going to happen once in a while no matter what, but we hope it won't happen often enough to be a problem.

Chairman PICKLE. We agree that we must not allow any more delay. These people are disabled and they need their money, at least in their mind, quicker than anybody else.

Mr. HAYS. With continued benefits through the ALJ level that problem is also minimized; payments for cessation cases are continued through the ALJ level now.

Chairman PICKLE. Could you start again?

Mr. HAYS. The problem that you were referring to has been partially mitigated by the fact that many cases receive continued benefits. In other words, their benefits don't have to be restored after the ALJ decision because they are already receiving benefits, so part of that problem went away as a result of the continued benefit provision.

Chairman PICKLE. This is a problem. You set up a unit——

Mr. SIMMONS. A special unit to handle cases where there is a problem in order to expedite getting the checks out. We know what the problem is. We are not studying it. We are doing something about the problem.

Chairman PICKLE. Earlier, Mr. Secretary, you said that you had been holding informal working groups with different groups in the mental impairment area.

What is the status of these working groups? Are you continuing them?

Mr. SIMMONS. When you use the word "informal," that implies something that is not there.

We are setting up groups with outside experts. They call it informal because we didn't publish something in the Federal Register, which takes 6 weeks to 45 days in order to just get the thing published. We are calling on expertise from the health professions and from interest groups that represent the handicapped, and we are hoping to have a good cohesive team put together, including some State people, including our own people and NIH people to help us look at these standards.

We are proceeding as fast as we can. We hope to have a product out of many of them by the end of this summer.

Chairman PICKLE. Mr. Secretary, I said earlier we were going to submit to you several questions, and we will do that. We will try to get them to your office by tomorrow.

Mr. SIMMONS. We will get the answers.

Chairman **Pickle**. The staff says they will hand deliver them tomorrow.

Mr. **Simmons**. We will hand receive them. Don't put them in the regular mail. We never get our mail there.

Chairman **Pickle**. The week of July 8 we hope we will have your response to them. We are not trying to nail you to it, but we need to know your general position on the problems we face here. We are under time constraints.

I appreciate your cooperation this morning. I know it has been a long hearing and I know at times you thought it was an adversary proceeding, but not intentionally.

I will just say, Mr. Secretary, in the words of an old country song, there's going to be some changes made. I hope we can make them together.

Mr. **Simmons**. I hope we can, too, sir.

[The questions and answers follow:]

COMMITTEE ON WAYS AND MEANS,
Washington, D.C., July 1, 1983.

Mr. PAUL SIMMONS,
Deputy Commissioner for Programs and Policy, Social Security Administration, Department of Health and Human Services, Hubert H., Humphrey Buildings. 200 Independence Avenue, S.W., Washington, D.C.

DEAR MR. SIMMONS: As you will recall, I indicated during the course of your testimony before the Subcommittee on Social Security that we would be sending you some additional questions in writing. I would appreciate your prompt response to the attached questions since the Subcommittee does plan to proceed rapidly to the consideration of legislation proposals.

With best wishes.

Sincerely,

J. J. PICKLE,
Chairman, Social Security Subcommittee.

Enclosures.

As I understand the process, a disability applicant, whose claim has been denied after an initial determination, faces an administrative appeals process consisting of a reconsideration, a hearing and an appeals council review. What are the current average processing times for each step?

The national average overall monthly processing times for disability cases in May 1983 were:

Initial decisions on applications	Title II Title XVI	64.7 days 68.5 days
Reconsiderations of initial decisions on applications	Title II only 1/	49.5 days
Hearings 2/	Titles II, XVI and concurrent	184 days
Appeals Council 2/	Titles II, XVI and concurrent	80 days (est.)

1/ Data on Title XVI reconsideration processing times are not currently available.

2/ Estimate; includes appeals of both initial denials and CDI terminations; actual current Appeals Council processing times [illegible] available.

What problems would arise from doing away with one step of the five-level appeal process? Wouldn't it save time, effort and money, and be a more efficient way of processing claims?

We assume the question relates to eliminating reconsideration.

We think that strengthening the reconsideration process by initiating a face-to-face evidentiary hearing at reconsideration in CDI termination cases, as P.L. 97-455 provides, is far preferable to and more efficient than eliminating reconsideration.

A face-to-face meeting with the decisionmaker will make reconsideration more meaningful and more responsive to the beneficiary than the existing paper-oriented review, and will also make more information about the beneficiary's condition available to the decisionmaker. This can be expected to result in accurate decisions earlier in the adjudicative process, thus giving many beneficiaries more prompt relief since they would not have to proceed to an ALJ hearing. We have conducted pilot programs to test the face-to-face hearing at reconsideration in three States--California, New Mexico, and Texas--and the pilot results bear out our expectations; the allowance rate under the pilot project was more than double the rate under the paper reconsideration process. Since the pilot results have been favorable, it would seem imprudent to eliminate reconsideration before seeing the effects of full implementation of the evidentiary hearing at reconsideration.

The evidentiary hearing at reconsideration will also reduce the tremendous ALJ workloads and improve ALJ case processing times, since more appeals will be resolved at reconsideration and since there will be better case development of those cases which are appealed to the ALJ level. Moreover, reducing the number of ALJ hearings will reduce administrative costs, since a reconsideration hearing will cost less than a ALJ hearing.

Elimination of reconsideration would have a very deleterious effect on ALJ workloads since it would innundate the already backlogged ALJ hearing level with still further appeals. Even assuming an increase in the number of initial continuances if a face-to-face meeting with the initial decisionmaker were instituted at the same time reconsideration was eliminated, there would still be unmanageable ALJ workloads and long delays before beneficiaries would get a decision on their hearing request.

I understand that the budget for the Office of Hearings and Appeals has grown 84 percent since 1980. Why have you felt this extraordinary increase to be necessary here, in light of a general tightening elsewhere in SSA?

The budget for the Office of Hearings and Appeals (OHA) has increased from $133 million in FY 1980 to $208 million for FY 1983--a 57 percent increase. This increase has been necessary to enable OHA to manage its growing hearings and appeals workloads. From FY 1980 to FY 1983, hearing requests have risen 43 percent (from 252,023 to 360,000), reviews before the Appeals Council have risen 119 percent (from 49,742 to 108,774, including 21,700 "Bellmon" reviews), new civil actions filed in Federal Courts have risen 140 percent (from 7,814 to 18,723), and Federal Court remands have risen 62 percent (from 3,320 to 5,393).

With respect to the hearings and appeals process, only the hearing itself was mandated by statute until the 1982 Disability Amendments. The 1982 Amendments require that, effective January 1984, beneficiaries shall be offered the opportunity of a face-to-face interview at the reconsideration stage. Please describe the Administration's efforts to implement this requirement? Describe the new Office of Disability Hearings?

SSA has already begun its efforts to establish a nationwide evidentiary hearing process at the reconsideration step in the appeals process. Several major tasks have been completed or are nearing completion:

a. Hearing design, regulations and procedures--We have designed a hearing process that offers claimants the benefit of all major due process rights. In designing the hearing, we have adopted aspects of other existing and well-tested processes. A Notice of Proposed Rulemaking which explains the key elements of the process will be published in the near future.

   The design calls for State Disability Determination Services (DDSs) to perform case development activities in support of the hearing process which are similar to their present reconsideration case development activities. We have drafted procedures to be followed by DDS and District Office staff and the Federal hearing officers. Quality assurance review procedures for hearing decisions are also being prepared.

b. Pilot of planned process--We have tested the hearing design as well as a preliminary set of procedures in three pilot hearing units. The pilots have shown that the hearing design, with minor modification, will provide meaningful and efficient hearings. A detailed analysis of the pilots and their results is now being prepared.

c. Workload and staffing projections--Using estimates that were modified after consideration of the preliminary results of the pilots, we have projected the average workload capacity of a hearing officer conducting this process. We have also determined the level of clerical support required. Assumptions concerning the nature and extent of DDS case development have also been assessed and modified as a result of the pilots.

d. Location of offices and space acquisition--We have used a mathematical model to select a national array of hearing unit sites based primarily on caseload distribution. Applying the model to the nationwide caseload distribution without being constrained by State boundaries enabled us to select 57 hearing sites which will provide full support for the hearing process with the fewest staff resources. The sites were selected with the objective of making the hearings at least as accessible to claimants as ALJ hearings currently are. Hearing officiers assigned to some of the units will be required to travel to conduct hearings. We are now acquiring office space for the hearing units. Preliminary procurement actions, including identification of specific office location, have been completed for 31 sites thus far.

e. Recruitment--We have established positions and specified qualification requirements for the hearing officers. The recruitment process will begin in about 2 weeks. In order to qualify, individuals must have extensive disability adjudication experience.

f. Training--Training for the hearing officers is being designed. Because the individuals to be selected will have extensive disabilty adjudication experience, only 1 week of program refresher training will be provided. In addition, a 2-week course covering the due process rights of claimants and the conduct of hearings will be provided. Training packages for DOs, DDSs, Quality Assurance staff, and supervisors are also being prepared.

g. Systems--Automated systems for scheduling hearings, case control, and management information are being designed and programmed. We are also procuring word processing equipment for the hearing units.

To administer the process, SSA is establishing the Office of Disability Hearings. This office will consist of the 57 hearing units, 7 regional offices (ROs) and a Baltimore headquarters staff. The hearing units will be staffed by approximately 210 hearing officers and 135 clerical employees. The ROs will provide management technical support for the hearing units and will coordinate case development activities with the DDSs. The RO will also operate the hearing scheduling system and will provide backup for any hearing units requiring temporary assistance in handling their caseloads. Aproximately 60 employees will staff the ROs. A headquarters staff of approximately 60 employees will provide policy and procedural guidance, conduct the final stage in the quality review process, and provide administrative support to the ROs and the hearing units.

What manpower has been hired?..Has been diverted from other components?

Nationwide, 26 employees are currently working on the hearing process. Six of these individuals have been formally hired into the organization, 16 have been detailed on a full-time basis, and 4 have taken positions in the organization as part of an SSA management development program.

How many hearings officers do you project? At what grade level?

Using a nationwide mathematical model, and applying pilot project results, we project a need for 210 hearing officers in FY 1984. This projection is based on an anticipated annual caseload of 110,000. There will be 40 GS-13 supervisory hearing officers and 170 GS-12 hearing officers.

What do you estimate as the total annual cost of the Office of Disability Hearings?

We expect the total annual cost for ODH to be approximately $21.2 million.

What impact do you expect on the processing times of the reconsideration?

We anticipate a 65-day average processing time from the filing of a reconsideration request to the issuance of a decision under the new procedure. The estimate is supported by experience under the recently completed pilot projects. The average processing time in the pilots was 63 days--only 7 days longer than the average processing times for CDI cases for the "paper review" reconsideration process in place in the three States prior to implementation of the pilot.

I'd like to explore the relationship of the reconsideration to the hearing. How many administrative law judges (ALJs) are currently on duty? (699 in 1981.) Their annual caseload? Average disposition per ALJ?

During May 1983, we had, on the average, 793 ALJs on duty. Total caseload figures for FY 1982 and FY 1983 (estimated) are as follows:

	FY 82	FY 83 (est)
Receipts	320,680	360,000
Dispositions	296,548	328,000
Cases Pending	152,896	184,896

For the first 8 months of this fiscal year, the average number of receipts per ALJ was 305. The average number of case dispositions per ALJ was 280, or 35 dispositions per ALJ per month.

What portion of this caseload do CDIs represent?

During the first 8 months of this fiscal year, CDIs accounted for 35.2 percent of request for hearing receipts and 30.0 percent of case dispositions.

What is the current ratio of support staff to ALJ?

During May 1983, the average support staff ratio was 4.6:1.

How did you arrive at the number of hearings officers to recruit for the reconsideration interview? What will their ratio of support staff be?

We calculated both the number of hearing sites and the number of hearing officers needed to fully support the new evidentiary hearing reconsideration process by using a mathematical site selection model. The model was designed to select a national array of reasonably accessible hearing sites that would also result in the lowest hearing officer staff requirement. The model identified 57 sites according to national caseload distribution. The site selections were made without consideration of State boundaries.

To calculate the number of hearing officers needed to staff the 57 hearing units, we considered three basic factors: (1) the number of reconsideration decisions the average hearing officer could make per day based on our experience with the pilot evidentiary hearing; (2) the impact on (1) of hearing officer travel necessary to make the hearings reasonably accessible to persons requesting them; and (3) the projected annual caseload to be handled by the hearing officers (110,000). Based on consideration of these factors, we estimate that 210 hearing officers will be required to support the new reconsideration process.

We also estimate that 135 clerical staff will be required to support the 210 hearing officers distributed among the 57 hearing sites. No new professional support staff will be hired since we will use existing DDS resources to carry out case development responsibilities. We arrived at this figure based on our experience with staffing the pilot hearing sites.

How many States have been given a reprieve on the CDI process?

See attached chart.

States for Whom Periodic Review Case
Workloads Have Been Temporarily Halted,
on a Month-by-Month Basis

UNITED STATES		7/82	8/82	9/82	10/82	11/82	12/82	1/83	2/83	3/83	4/83	5/83	6/83
Boston	Connecticut		x										
	Maine	o	x	x	x								
	Massachusetts		x	x	o	o						x	x
	New Hampshire		x										
	Rhode Island		x	x	o	x	x		x				
	Vermont		x										
New York	New Jersey	o	x	x	x	x	x						
	New York		x		o	x	x			x	x	x	x
	Puerto Rico	o	x		o	o							x
Philadelphia	Delaware		x	x	o	o	x	x					
	District of Columbia		x										
	Maryland		x	x	o	x	x	x	x	x	x	x	
	Pennsylvania		x	x	o	x	x		x				
	Virginia		x						x				
	West Virginia		x	x	o	x							
Atlanta	Alabama		x										
	Florida		x	x	o	x	x	x					
	Georgia		x										
	Kentucky		x	x	o	x	x	x	x	x	x		
	Mississippi		x										
	North Carolina		x										
	South Carolina VR		x										
	Bing												
	Tennessee		x										
Chicago	Illinois		x									x	x
	Indiana	o	x	x	o	x	x	x	x	x		x	x
	Michigan		x	x								x	x
	Minnesota		x	x								x	x
	Ohio		x	x	o	o						x	x
	Wisconsin		x	x	o	x	x	x	x	x		x	x
Dallas	Arkansas		x										
	Louisiana		x	x									
	New Mexico		x	x									
	Oklahoma		x	x	o	o							
	Texas		x	x	o	x							
Kansas City	Iowa		x										
	Kansas		x										
	Missouri		x										
	Nebraska		x										
Denver	Colorado		x	x	o	x	x	x					
	Montana		x										
	North Dakota		x										
	South Dakota		x										
	Utah	o	x										
	Wyoming		x										
San Francisco	Arizona		x										
	California		x										x
	Guam		x										
	Hawaii		x		o	x	x						
	Nevada		x	x									
Seattle	Alaska		x										
	Idaho		x										
	Oregon		x										
	Washington		x										

Months indicated are months for which no cases were sent. State agencies may have received some of prior months' workload during months in which case flow was halted.
x Indicates months in which flow of cases was halted by computer. Stoppage was complete.
o Indicates months in which flow of cases was halted manually. Stoppage may not have been complete.

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What would the cost be of continuing Medicaid coverage for SSI recipients for 2 years as Medicare now continues for SSDI recipients?

To provide Medicaid coverage for disabled SSI recipients for an additional 24 months after their SSI benefits had terminated because they had completed a 9-month trial work period, engaged in substantial gainful activity (SGA), and had completed the automatic reentitlement period, would have the following costs. (This provision would not apply in cases where SSI benefits are terminated because the medical impairment is no longer considered to be disabling.)

The estimates are based on an assumed effective date of January 1, 1984, after the 3-year demonstration project provision in section 1619 of the Social Security Act (based on the amendment in section 201 of P.L. 96-265) expires on December 31, 1983. This provision guaranteed certain disabled and blind SSI recipients that their Medicaid eligibility would continue even though they engage in SGA and their Medicaid eligibility and SSI eligibility otherwise would have terminated.

Cost (in millions)

	FY 84	FY 85	FY 86	FY 87	FY 88
Federal	3.1	3.6	3.9	4.4	4.8
State	2.7	2.9	3.3	3.5	4.0

Do physicians write the regulations or are they consulted in writing the regulations?

Social Security Administration physicians are involved in formulating regulations, policy and procedures involving medical issues. They have primary responsibility in researching and revising the Listing of Impairments. The Listing describes, for each of the major body systems, impairments which are considered severe enough to prevent a person from doing any gainful activity. In addition to participation by SSA program physicians, physicians outside the program are also appropriately consulted. This includes the APA, AMA and other medical professional societies as well as physicians involved with impairment-related interest groups.

As part of the regular clearance process for all regulations, the Listing is submitted to other SSA components, as well as to the Department of Health and Human Services and the Office of the General Counsel, for clearance. In addition, SSA program physicians review and comment on all medically related disability regulations e.g., the regulations pertaining to acceptable sources of medical evidence and to the purchase of consultative medical examinations. Of course, physician comments are also received and considered as part of the public comment process.

What difficulties would be posed by a national fee scale for consultative examinations by physicians?

The regulations authorize the States to determine the rates of payment to be used for purchasing consultative medical examinations but provide that the rates may not exceed the highest rate paid by Federal or other agencies in the State for the same or similar service. In the past, States have opposed having the Federal Government set the fees paid for consultative examinations.

If SSA required the States to pay higher rates for medical examinations purchased for Social Security purposes than the States choose to pay under other State-administered programs, the States would have difficulty justifying varying rates to physicians and could lose physicians in the lower-paying programs. The result would be pressure on the States to raise rates for all medical examinations and most States simply could not afford to do this. On the other hand, if SSA set a national fee scale that was lower than the rates now paid in some States, those State DDSs would be unable to find physicians to do consultative examinations. However, individual State problems of low fees must be addressed and solutions found so that claimants are not disadvantaged. Those solutions must consider specific issues related to the States involved.

What disability training do you demand for state agency personnel, especially the disability examiners?

SSA regulations contain accuracy and processing time standards for State agency disability determinations but leave largely to State agency discretion the methods used to achieve these goals. The regulations provide that States must insure an acceptable level of employee competence and that SSA will conduct or require specific disability training only if (a) a State's performance approaches unacceptable levels; or (b) the training material is complex or the capacity of the States to deliver the training is doubtful.

SSA does, however, develop and provide training materials and conducts disability training to facilitate proficiency of State disability staff. For example, we collaborated with the States in designing and supplying a Disability Examiner Basic Training Program. This course is widely used by States to train new examiners and is revised by SSA on an ongoing basis to reflect major national policy and legislative changes, as well as being supplemented by individual States to reflect their own administrative needs.

Whenever we revise instructions in the manuals State agency disability examiners use, we supply training materials for State use if we believe instructions are necessary. In addition, we develop and conduct specialized training in response to specific program needs; for example, we supplied a continuing disability review examiner training package, we are holding vocational factors training sessions for State agency personnel who do vocational evaluations, we have provided training materials on the use of the new Dictionary of Occupational Titles, and we have held training sessions for regional medical personnel who, in turn, train State agency medical personnel.

SSA regional offices develop training materials (subject to headquarters policy approval) and conduct training sessions in response to local needs. Also, if a State experiences performance problems, a Fiscal, Administrative and Management Review team, composed chiefly of SSA regional personnel, examines all aspects of the State agency's operations, including training, and makes specific recommendations on how to correct deficiencies. The regional office then may design training programs tailored to the State's needs.

Finally, we are preparing a basic refresher training seminar for all disability examiners and reviewers in SSA and the DDSs. This program will begin early in fiscal year 1984.

What disability training do you require for claims representatives, who actually receive disability claims, after their initial three month claims representative training course?

We require no formal course of training for claims representatives after they complete their basic claims representative training course. Rather, we develop and distribute orientation materials, job aids and training packages at the time we implement major program changes, significantly revise procedures or issue new operating instructions. Also, regional and district offices are authorized to provide appropriate general or specialized disability training in response to the needs of a particular office. In addition, many district offices invite speakers from a nearby DDS to discuss items of interest or permit their disability staff to visit a DDS to meet the staff and to observe first-hand how claims are processed in the DDS. At the present time we are involved in several district office-related initiatives which include training. We have produced a training program for claims representatives which involves refresher training on general disability program concepts and specific training on interviewing disability applicants.

The 1982 Amendments permit the face-to-face reconsideration interview to be conducted either by a state or federal employee. I understand, at least initially, you are using federal employees in implementing this additional step in the process. Is this correct? Will some be recruited from the states? How will this impact on state operations?

The legislation gives the Secretary the option to either appoint Federal hearing officers or delegate this reponsibility to the States. In implementing this new reconsideration process, we will be using a cooperative State/Federal approach in which State employees will develop cases for hearing, allowing claims where appropriate, and in which Federal employees will conduct hearings. This process will largely preserve the existing State procedures and resources for reconsideration development. It is designed to minimize the disruption of DDS functions while ensuring nationwide uniformity in the hearings process.

The actual face-to-face portion of the hearing process will be administered by a single nationwide SSA office, providing consistency in conduct of hearings and decision writing. This approach will also require the lowest number of hearing officers by using a efficient nationwide distribution of resources.

We expect that the majority of hearing officers will be recruited from the States. However, because the Federal government can recruit in all States for each of the 57 units, no one State is expected to be greatly affected. For example, assuming that 80 percent of the hearing officers are recruited from States, 168 employees would be recruited from 52 agencies; an average of 3.2 per agency. A State like California, with 6 hearing units, would naturally be the source for more recruited hearing officers that the average. However, the size of the existing California staff and the possibility of recruiting many of the California hearing officers from elsewhere in the country will mitigate any potential harmful effects on the California DDS.

What percent of denied disability applicants file for a reconsideration? For a hearing? What percent of those terminated as a result of CDI's file for reconsideration? For a hearing?

We are unable to supply the percentages requested because we do not have longitudinal information on each case as it moves through the various levels of appeal. The statistics in the table below relate to workloads processed at the various levels for the given time period but it must be kept in mind that, for example, the appeal requests processed in a given period will include some cases where the initial denial or termination decision was made in the prior period as well as cases where the initial denial or termination decision was made in the same period.

Appeals of Unfavorable State Agency Decisions 1/
FY 1983 to date (October 1982-March 1983)

	State Agency Decisions	Reconsideration Requests	Hearing Requests
Initial Denials	465,000	185,000	117,000
CDI Terminations 2/	101,000	79,000 3/	57,000

1/ Figures rounded to nearest thousand and include Title II, Title XVI and Title II/XVI concurrent cases except where noted.

2/ Includes medical diary cases as well as periodic review cases.

3/ Title II only; title XVI and concurrent title II/XVI cases go directly to ALJ hearing.

Would eliminating the reconsideration step, and offering a face-to-face interview at the initial decision -- to those who would otherwise be denied medically -- be more cost effective than the process now in place for January, 1984?

Replacing the existing legislatively mandated process with one that requires a face-to-face interview at the initial decision would not be more cost effective. A face-to-face meeting would have to be provided to all claimants who would otherwise have their disability ceased.

In contrast, under the process being planned for January 1, 1984, only those claimants who disagreed with the initial decision and filed for reconsideration would have the opportunity for a face-to-face meeting. Under the payment continuation provisions, 90 percent of beneficiaries who are notified of an initial determination that disability has ceased request reconsideration. The pilot project results show that 18 percent of those who filed for the reconsideration level hearing had their cessation decision reversed without a personal appearance. Consequently, over 25 percent fewer face-to-face proceedings would be required under the current plan than under one which provided a face-to-face meeting at the initial level.

More importantly, the face-to-face interview at the initial level could not be as meaningful to claimants or as effective in arriving at correct decisions early in the process. The claimant would not have an opportunity to assess an initial determination rationale prior to appearing at the face-to-face proceedings and, therefore, would be less able to identify and provide relevant evidence. This is precisely the situation that the due process guarantees provided under the new reconsideration process are designed to prevent. The pilot projects of the new process had an overall allowance rate of approximately 38 percent. This rate would not likely be achieved by providing a face-to-face interview at the initial level. In fact, previous studies assessing only the face-to-face meeting element resulted in only a 10 percent increase in allowances.

Because of these inadequacies, under a face-to-face interview process at the initial level, a greater number of cases would proceed to the ALJ level, than under the process being planned for January, 1984. ALJ hearings involve lengthy processing times and the greatest cost per case. Despite massive increases in staffing and resources at the ALJ hearing level during the past 2 years, the pending caseload and processing times are continually reaching new record levels. The pending caseload before the ALJs now stands at more than 171,000 cases, and has grown by almost 43,000 cases since the end of FY 1981. We estimate that eliminating reconsideration and offering a face-to-face procedure at the initial level, if applied only to cessation cases, would result in a 1-year increase in pending cases of 43,000. Alternatively, SSA would have to hire an additional 150 ALJs to handle just the increased workload. A hiring effort of less than this magnitude that took place in 1982 strained the recruiting capability of SSA and severely depleted the pool of potential candidates. Such an effort could not be successfully repeated within the next 5 years. In addition, approximately five support staff would be required for every newly-hired ALJ. The total staff increase would therefore be 900 employees.

If reconsideration were eliminated for initial application cases as well, the impact on staffing would be several times greater.

In order to process the estimated 742,500 ALJ receipts per year for initial application cases and the 113,400 ALJ receipts for cessation cases, SSA would be required to triple the number of ALJs on board to over 2,300.

Chairman PICKLE. Thank you very much.

Let me ask in view of a 2 p.m. session scheduled for Mr. Cohen, I will ask the GAO to step aside for 1 minute, if that is agreeable, and let me ask Secretary Cohen and former Commissioner William Driver and Mr. Ivan Cotman to come to the table.

Is Mr. Peter McGough here? Is that all right to allow these gentlemen to proceed?

Thank you for your cooperation. We won't hold you long either, but these gentlemen have a meeting.

The Chair is pleased to recognize these two gentlemen. They have served in HEW and SSA Commissioner, and are able, distinguished, caring individuals. We are proud to have them here to present their testimony.

Mr. Cotman, we are pleased to have you here also.

Mr. Cohen, we will recognize you first on the basis of seniority and reputation and anxiety or any other concern.

STATEMENT OF HON. WILBUR J. COHEN, FORMER SECRETARY OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY WILLIAM J. DRIVER, FORMER COMMISSIONER OF SOCIAL SECURITY; AND, IVAN COTMAN, ASSOCIATE SUPERINTENDENT FOR REHABILITATION, STATE OF MICHIGAN, ALL ON BEHALF OF SAVE OUR SECURITY COALITION

Mr. COHEN. Mr. Chairman, it is a delight for me to be a voting resident of Austin, Tex. I am very pleased to be here today with my two colleagues, whom I brought along because I believe that questions directed to a former Secretary and a former Commissioner and a present State disability determination official who is responsible for the State, will give you representation of experiences in the totality of this program.

Chairman PICKLE. Let me interrupt you. I did not say that Mr. Cotman is the director of the disability determination for the State of Michigan. I should have made that delineation.

Mr. COHEN. The disability program is the most complex and, I would also add, controversial program in the entire social security program. It is unique among all programs since it provides not only a Federal financial base like social security retirement, but uses State agencies not in the cooperative Federal-State partnership like we have in unemployment compensation or in aid to dependent children [AFDC], but it uses the States as administrative agencies financed 100 percent by Federal funds

So it is a very unique program, and the characteristics of it bring the legal, political, economic, and social problems that are very complex.

Now, I would like to ask that my full statement and appendixes be put in the record, and I will go over these points quickly in the hopes that those that interest you, you will ask me questions about, rather than me continuing with it.

Chairman PICKLE. Your full statement will be put in the record.

[The prepared statement follows:]

STATEMENT OF WILBUR J. COHEN, CO-CHAIR OF SAVE OUR SECURITY, PROFESSOR OF PUBLIC AFFAIRS, LBJ SCHOOL OF PUBLIC AFFAIRS, THE UNIVERSITY OF TEXAS AT AUSTIN

Mr. Chairman, and Members of the Subcommittee, this is the first opportunity I have had to appear before this distinguished Subcommittee since the passage of the 1983 Amendments. I wish to compliment the Members for their statesmanlike actions in enacting that important legislation. While there are provisions in the new law with which I strongly disagree (as is the case for probably everyone), it was a remarkable constructive achievement. It should help to restore faith in the social security system. We in the Save Our Security coalition want to do our part to help restore this faith in the system and in the Congress as the responsible Board of Directors of an important and sound system.

However, the disappointment and frustration with the way the disability program is being administered is greater in intensity than the fear and anxieties which existed— and still exist—with respect to Congress' handling of the financing of the old-age program.

I appreciate the opportunity to testify today on the subject of disability insurance and assistance benefits. I participated in the research and planning for the disability program from 1938 to 1955 in the Social Security Administration. I first worked with the committee on Ways and Means and Chairman Doughton in 1949 on the subject when the Committee voted passage of the first disability insurance legislation. The Senate did not act on the subject in 1950 and the Conference Committee in 1950 adopted a Federal grant-in-aid program for disability assistance as a step in order to obtain some experience on the matter.

In 1952 I handled the first disability freeze amendment proposed by Mr. Kean, Republican of New Jersey, before this Committee and in Conference with Chairman Doughton and Mr. Mills.

The House Ways and Means Committee adopted disability insurance a second time in 1955 and the Senate adopted it in 1956. I prepared the Senate draft of the disability insurance bill for Senator Walter George and acted as his consultant in the Senate debate which resulted in a close vote of 47-45. The Conference Committee, of course, accepted the program in view of the fact that the subject was in both the House and Senate bills.

I have reported the issues and actions of the historical development in my book, Retirement Policies Under Social Security, 1957, Chapter IV. I worked on the disability amendments of 1958 and 1960 and handled the social security amendments for the Administration in 1961, 1965 and 1967.

Secretary Flemming was in office during 1958 to 1961 when the disability program was being inaugurated and expanded. He strongly supported the 1958 and 1960 amendments to the disability program.

Since 1979, I have attempted to follow the disability programs and policies. I must say to you honestly that this period had been the most disappointing and frustrating episode in the 48 years I have worked on social security issues. As you know, my colleagues in SOS and I have been critical of both some of the Carter and Reagan Administration's recommendations in disability, and even more indigant at the harsh an unfair administrative policies followed by the Social Security Administration since 1981. We also have not been fully in accord with all the actions of this Subcommittee—and I am sure the Subcommittee has not been enthusiastic about many of our insistent recommendations, proposals and views. Perhaps we have all made mistakes and now is a good time to turn over a new leaf. We urge you to take strong and prompt action to remedy the present sad state of affairs which is ruining the reputation of social security among many contributors, beneficiaries and the staff.

ADMINISTRATION

The most distressing fact to me, Secretary Flemming, and the several former Commissioners and officials who I am representing here today, is the grave deterioration in the quality of service in recent years by the Social Security Administration.

Under Mr. Altmeyer, Commissioners Framburg, Schottland, Mitchell, Ball and Driver, and Secretaries Flemming and Richardson, a high level of quality of service in social security was performed, expected and nurtured. Irrespective of political affiliation, they believe in a nonpartisan public service and the highest standards of performance throughout the program. Social security earned a high—usually the highest—rating among taxpayers, recipients and Members of Congress for the quality of service provided, the courtesy, compassion and efficiency.

Some of the reasons for this deterioration is due to unwise Administration policy, some to unfortunate appropriation limitations, some to the interference of the Office of Management and Budget, and some to the complex Federal-State administrative structure of the program.

We do not believe that the many serious difficulties which have plagued the disability program would have occurred in the form they did if the program was administered by an independent Social Security Board as it was in the beginning of the program.

We urge, therefore, that the study of the independent agency provision in Section 338 of the 1983 amendments be implemented as rapidly as possible. It is of major importance. To effectively administer the 1980–83 amendments, an independent, nonpartisan Board is imperative. We urge the Chairman of the Ways and Means Committee to appoint his selection to the joint study panel in the very near future.

PERSONNEL

Because of unrealistic personnel ceilings, there is insufficient staff, especially in local district offices and in the regional offices, to carry out the vast statutory responsibilities you have placed on social security. I continue to visit local social security officers in every community I visit. I keep in touch with them. They are doing a splendid job under very difficult circumstances. But they need more personnel.

Do not place additional responsibilities on social security or the State disability determination agencies without assuring an adequate number of trained personnel and sufficient lead time to implement any changes in an efficient manner.

The most important action you could take is a one-year moratorium on the personnel ceilings imposed by the Administration. Keep in mind the financing of these disability insurance personnel costs do *not* come from general revenues but are paid entirely from employer-employee contributions.

SUPPORT FOR H.R. 2987

SOS, in conjunction with organizations representing the disabled, supports H.R. 2987, the excellent bill introduced by Representatives Shannon and Stark. This bill is wholeheartedly supported by both Secretary Flemming and myself; by Commissioners Ball, Schottland, Driver, Bechill and Martin; and by Nelson Cruikshank, the former Counselor to the President for aging. It represents our best considered judgment at this time.

I submit for the record a summary of the provisions.

ADMINISTRATIVE LAW JUDGES

We recognize the many problems surrounding the status of the administrative law judges and the arguments in favor of some changes in their status to continue to assure their independence. However, I also recognize that they must work within the statutory language, the legislative intent and the regulations.

However, I would not be precipitate in making basic changes at this time affecting the role of ALJs. First, I would hope you would enact Section 307 of the Shannon-Stark bill, H.R. 2987, enabling the number of ALJs to increase over time, and to obtain a report on this development before proceeding further.

Second, I would await the report under Section 338 of the 1983 amendments on the establishment of social security as an independent agency.

Finally, we wish to offer the advice of our Executive Vice Chair, William Driver, who was both the Administrator of Veterans Affairs (which has a somewhat different appeals process) and Commissioner of Social Security. Along with Secretary Flemming, Commissioners Ball and Schottland, and Director John J. Corson of our organization, we have many man-years of experience on the appeals process which we offer to the Congress for your review before making a critical decision in this area.

COURT ACTION

We believe that where a Circuit Court order has not been appealed by one of the parties within 45 days, the Secretary should put the Court's decision into effect nationwide within 60 days of such decision.

ASSOCIATE COMMISSIONER FOR DISABILITY POLICY

Disability policy is important enough to warrant a full-time, high-level person to concentrate on disability policy. Consideration might be given to the appointment to such a position with the advice and consent of the Senate. This would be unusual but the disability program is unusual. The present Administration has bungled the entire policy formulation process and Congress should exercise a greater oversight responsibility of the program.

COMMISSIONER OF SOCIAL SECURITY

Mr. Svahn is the most recent Commissioner of Social Security. But recently he was appointed Under Secretary of Health and Human Services. I was the Under Secretary for nearly three years. I can tell you it is a full-time job—and more so. I think Congress should indicate its disaffection with the absence of a full-time Commissioner of Social Security and with the policy of permitting the Under Secretary to act as if he were also the Commissioner. I urge you to consider inclusion of an amendment to any bill you report to preclude continuation of the present situation or to handle this matter in your Committee Report.

ANNUAL REPORT

Section 704 of the Social Security Act requires the submittal and publication of an Annual Report by the Secretary on the administration of the Act.

This statutory requirement has not been complied with strictly in recent years. I believe a full annual report on the disability program is needed and should be required by statute. In this way Congress and the American people would have essential information needed for both legislative review, the appropriations procress, and for public education. I urge your adoption of a special amendment to require such action.

SSI DISABILITY

We urged and supported section 405 of the 1983 amendments which provides for notification to all OASI recipients of the availability of SSI benefits. However, we believe there is a defect in the law in that it does not include the blind and disabled for SSI.

We strongly urge amendment of the existing law to include the blind and disabled within its purview.

CONCLUSION

On several occasions Congress has taken action too broadly and too quickly without due regard to technical, administrative and personnel implications of social security and disability.

Social security is a big program. With 36 million beneficiaries drawing benefits each month and 116 million contributors, it needs careful, sensitive, planned treatment. Diagnosis of a disease is one skill; treatment is often a very different one. And rehabilitation takes a third skill.

We need prompt action—but also effective and compassionate action.

It is more efficient to eat all three meals at once and save the time, effort, and dishwashing. But it has the disadvantage of indigestion. We now have disability indigestion from the actions and inactions of Congress and the Administration. Be wise and careful at the same time in what amendments you propose.

Please give us adequate opportunity to comment on your proposed recommendations.

I am authorized to say that Secretary Flemming is in full accord with the views I have expressed in this statement.

I know there are many complex questions with which you are concerned. I will be glad to answer questions to the best of my ability.

Thank you very much.

Mr. COHEN. The first part of my statement is to thank you for what you did with regard to the social security amendments, in which I expressed the view that despite my disagreement with some of them, I think it is one of the greatest accomplishments that you and your committee have done. I congratulate you for your statesmanship and the great ability you exercised in that performance.

Chairman PICKLE. The Secretary said he approved of 95 percent of those amendments, but he wanted another five.

Mr. COHEN. I hope we will still get them at a future date.

I want to make a point that in making my presentation today, I agree with what you and Mr. Gradison said. I am not going to try to find fault with what happened in the past.

I will say I share personally certain regrets that certain things that I was a party to during a period of time—one revises one's point of view with experience. I am not saying that things couldn't have been done differently. I did draft the disability program that became law in 1956. I was Senator George's staff person in 1956 that drafted the Senate amendment that became law which the conference committee adopted.

Just to make a point relating to what was discussed this morning, about which there is a lot of misunderstanding, we intended that you don't pay terminal illnesses immediately. That is not correct—we intended that the law be very tough in light of what Senator Pepper said. Those were all part of the legislative intent of 1956, which Jere Cooper, the chairman, and Mr. Mills then at that time agreed to.

I might have been a little reluctant, but I went along in 1956 with what is in the present law and the definition on the grounds that we needed experience. This was a wholly new program and I have recounted in my testimony—and if you want to go into detail about it, I have written a book about it, and you can read chapter V of the book telling how it all began.

I shared responsibility about this program in making it a tough program, setting up the appeals procedure the way it presently is in general and putting other provisions in the law which were designed to get us enough experience to find out what we needed to know and how we wanted to change the law in the future.

In testifying today, in my testimony, and I hope it is nonpartisan, because I represent not only Secretary Fleming, who was the Secretary in the Eisenhower administration, but also Mr. Driver, Mr. Ball, and Mr. Schottland, who were the commissioners in different administrations, and I represent also Mr. Bechill and Mr. Martin, who were the commissioners on aging as well as Mr. Cruikshank, who was the counselor to the President in the Carter administration when the amendments took place.

I represent all of them today. So I am not here to say who made what mistakes.

I will say this, probably in summary, we all made mistakes. I don't know of anybody who is—I doubt that I have been a perfect husband or teacher or father, but one does hope to learn by experience.

So I come before you today rather than telling you what has been wrong, how we can change the program to improve it.

Now, the most distressing fact to me and Secretary Fleming and the several former commissioners and officials whom I represent here today is the grave deterioration in the quality of service in recent years by the Social Security Administration. Under Mr. Altmeyer, under Commissioners Tramburg, Schottland, Mitchell, Ball, and Driver, and Secretaries Fleming and Richardson, a high level of quality of service of social security was performed, expected and nurtured.

Irrespective of political affiliation, they believed in a nonpartisan public service and the highest standards of performance throughout the program. Social security earned a high—usually the highest rating—among the Federal agency performances among taxpayers, recipients and Members of Congress for the quality of service provided, the courtesy, compassion, and efficiency.

If you would like the report of the study which demonstrated this, I can supply it for you.

Some of the reasons for this deterioration, in my opinion, is due to unwise administration policy, some to unfortunate appropriation limitations, some to the interference of the OMB and some to the complex Federal-State administrative structure of the program.

We do not believe that the many serious difficulties which have plagued the disability program would have occurred in the form they did if the program had continued to be administered by an independent, nonpartisan social security board as it was by Congress action in 1935.

So, therefore, Mr. Chairman, we believe that the study of the independent agency provision in section 338 of the 1983 amendments should be implemented as rapidly as possible. It is of major importance in order to effectively administer the 1983 amendments, disability and social security, that there be an independent, nonpartisan board is imperative.

We urge therefore that the study of the independent agency provision be started in the near future so that the study can be completed as provided by law on April 1, 1984.

Chairman PICKLE. We will start giving more attention to that.

Mr. COHEN. Mr. Chairman, I can't underestimate the importance of that.

Let me tell you my personal opinion. You are not going to get out of the woods on this disability thing until you make the Social Security Administration an independent, nonpartisan political board, because the present situation is that there is too much interference in the policy formation of the program from external sources that are not directed toward the kinds of problems that have been raised here today.

That is my considered judgment, sir.

Chairman PICKLE. I see a lot of heads nodding in agreement. I wish Commissioner Simmons had stayed. I assume he has a representative.

Mr. COHEN. I can only say that if I were Secretary and one of my subordinates answered the questions the way Mr. Simmons did, I would have fired him.

I don't believe that any question asked by a Member of Congress is irrelevant and I think that what we are seeing, sir, in this is policy directed by levels outside of the Social Security Administration that have nothing to do with disability.

Mr. ANTHONY. Mr. Chairman, I think at this point in time we need to ask unanimous consent for Mr. Shannon to revise and extend his remarks.

Chairman PICKLE. Mr. Shannon is going to be here shortly. At this point, leave him out of it.

Mr. COHEN. Mr. Chairman, because of unrealistic personnel ceilings, and this was so during my time as well, there is insufficient staff especially in local district offices and in the regional offices to carry out the vast statutory responsibilities Congress has placed on the social security program.

I continue to visit every local social security office in every community that I ever visit. I go and sit down, don't tell them who I am, I sit down and wait in line and see what is going on in the local office. I have done that in Austin, I have done that in Ann Arbor, I have done that in a lot of places.

Chairman PICKLE. And they don't recognize you?

Mr. COHEN. Yes, sir, especially the ones that have my picture in the back room do. But I think my present white hair and a little more corpulence don't always make it such that they do recognize me immediately.

I try to keep in touch with them. They are doing a splendid job under difficult circumstances, but they need more personnel.

I say to you when you come to make your amendments, do not place additional responsibilities on social security or the State disability determination agencies without assuring an adequate number of trained personnel and sufficient lead time to implement any changes in an efficient manner. That was our mistake in 1980, Mr. Chairman.

Chairman PICKLE. If we gave them the money for that and if we gave them the personnel, wouldn't the States then cooperate?

Mr. COHEN. Yes, sir. I did not mean to imply that.

I meant that in order to do what you have been talking about this morning, you have got to have trained professional personnel. You can't decide on Monday morning that you are going to have a new amendment affecting hundreds of thousands of people and handling hundreds of thousands of claims and appeals and reconsideration and so on and get that into shape.

Mr. Driver will speak to that as a former commissioner.

You need, many times, a year or 18 months lead time to put a highly complex controversial amendment in to accomplish what Mr. Anthony was talking about; that is, treating people in similar circumstances similarly in Arkansas and Texas. You can't do that by just issuing a piece of paper in a manual and then know that in 3,000 counties in the United States and in 50 States and jurisdictions, and with 75,000 social security employees, it is all going to happen instantly. It doesn't.

You have got to have training and background. That is why I say, Mr. Chairman, before we do whatever we are going to do in this, I would like to see us go to the Appropriations Committee or in some other way to establish at least in your committee report that the implementation dates are related to the staffing capacity and the money to do it.

I want to make one other point. The entire administrative cost for this program is not a penny out of general revenues. It all comes out of employer-employee contributions.

There should be no reluctance to give the quality of service, the quantity of service and to do what you want, and I will come to it on the face-to-face hearings.

Chairman PICKLE. I agree with you, but there is an OMB.

Mr. COHEN. Yes, sir, that is why——

Chairman PICKLE. It is your President.

Mr. Cohen. That is why I would like to see you take the 1983 amendment in which you took it out of the unified budget in 1982 and make it 1984. If you would do that, you would solve 90 percent of your problem, because all the problems you talked about this morning are due to the fact that the OMB wants to reduce the amount of social security disbursements in order to reduce the deficit.

I have asked people in Austin, Tex., and Ann Arbor, Mich., do they think that when they pay into the social security fund the amount of income or out-go has anything to do with the deficit, and I have yet to find a person who thinks so.

They think when they pay an earmarked contribution from their employer it is not part of that deficit. They do not know that Mr. Stockman uses every penny of reduction he can count on to reduce the deficit.

I think it is irrelevant.

Chairman Pickle. You said we shouldn't use that word in these hearings.

Mr. Cohen. I didn't say what Congress asks is, sir. But I think what Mr. Stockman demands is irrelevant.

The most important action you could take is a 1-year moratorium on any personnel ceilings in the program. Keep in mind the financing costs do not come from general revenues, sir.

Chairman Pickle. I have to ask you to yield. You were going to enter into the portion of you testimony in support of H.R. 2987.

We have a vote on and we have only 5 minutes left. We must go and answer that. We will come back.

In the meantime—have you voted?

Mr. Anthony. No, I haven't.

Chairman Pickle. So we will stand in recess for 10 minutes.

[Recess.]

Mr. Shannon [presiding]. Could I ask everybody to take their seats?

Mr. Cohen. I was just at the point in my testimony when we recessed when I deal with one of the most brilliant pieces of legislation recently introduced in Congress.

Mr. Shannon. Maybe we should wait until Mr. Pickle comes back.

Go ahead.

Mr. Cohen. What he suggested in this paragraph, then if you want to ask me some questions——

Mr. Shannon. Have you finished your statement?

Mr. Cohen. No.

SOS, in conjunction with organizations representing the disabled, supports H.R. 2987, the excellent bill introduced by Representative Shannon.

The bill is wholeheartedly supported by both Secretary Fleming and myself, by Commissioners Ball, Schottland, Driver, Bechill, and Martin; and by Nelson Cruikshank, the former Counselor to the President for Aging. It represents our best considered judgment at this time.

Perhaps you want to put the summary of your bill in the record rather than my doing it.

Now I take up two or three of the issues that the committee is dealing with.

First, the rather complex issue on the administrative law judges as such. We recognize the problems surrounding the status of the administrative law judges and the arguments in favor of some changes in their status to continue to share their independence.

However, as a former Secretary, I also recognize that they must work within the statutory language as passed by Congress, the legislative intent as incorporated in the committee reports, and the regulations.

However, my recommendation is I will not be precipitate in making basic changes at this time affecting the role of the ALJ's, other than what is contained in H.R. 2937.

I hope you would enact section 307 of the Shannon-Stark bill enabling the number of ALJ's to increase over time and obtaining a report on this development before proceeding further.

When Mr. Simmons talked he made the point that they have—I don't know whether he said appointed or selected or recommended 140 additional ALJ's. Now, I went to the Appropriations Committee yesterday and I asked them how many ALJ's there were. They told me 800. I don't know whether he is saying there are now 940 or there will be or whether that 140 was adding on to the 800.

I think, based upon a rather inexact examination of it, I think that we need about 1,000 ALJ's to do this job now within an appropriate time to give the ALJ's a reasonable performance conduct to handle the load. That is not a precise figure, but I think that is the reason why I favor your section 307 in your bill.

Before we make a comprehensive change, let's get the quantity and the quality of ALJ's up to handle this terrific workload to give the quality of service that the contributors and the clients need.

Second, I would wait for the report under section 338 of the 1983 amendment on the establishment of Social Security as an independent agency. I think once we got an independent agency, Mr. Shannon, 98 percent of these so-called political problems, including the ones that you enunciated this morning, would be eliminated.

No board in which there was a Republican and a Democrat and a chairman would have either answered the questions the way they were answered this morning nor would have done what has been done under the 1980 amendment, in my judgment.

Finally, we wish to offer the advice of our executive vice chairman, William Driver, who was both the Administrator of Veterans' Affairs and has had a unique experience in the appeals process and the Commissioner of Social Security, and Mr. Cotman, who is the administrator of disability determination in Michigan. So we have enough experience from the three of us plus the other people. We have a lot of years of experience right on the firing line for your review before you make a critical decision in this area.

Now, there was a discussion this morning, I think it was Mr. Anthony, and I want to tell you about our conclusion on the kind of issue raised by Mr. Anthony on court action.

I might add this represents both Secretary Fleming and my judgment and the judgment of another gentleman who was the Attorney General of the United States who is our adviser. We believe that where a circuit court order has not been appealed by one of the parties within 45 days, the section put the court's decision in effect nationwide within 60 days of the decision.

You pay a national tax under the social security program. Everybody under the same circumstances pays the same tax, the same employee tax, employer tax, self-employed tax.

The fundamental principle of this program ought to be that persons in similar circumstances ought to be treated similarly. That is the concept of equity that Mr. Anthony was propounding.

Now, of course, we all recognize that there are lot of legal problems in Federal district courts. When I left being Secretary, I think there were about 35 cases versus Cohen on disability, most of which I didn't personally happen to agree with, with the disallowance.

Why? I didn't take the cases to court and I was the nominal defendant, but it is the Justice Department of the United States who determines the cases to be taken to court, not the Secretary of HEW.

Legal decisions in the U.S. Government and appeals are not decided by the cabinet officer in charge of the program. They are decided by the Attorney General and his staff.

I had a lot of trouble explaining to my wife and to my lawyer son how I was in a case with what they thought was an absolutely wrong point of view. I had to tell them that it wasn't my decision.

I believe, therefore, that when a circuit court has spoken and if the Government does not want to appeal, then you ought to put that rule of law into effect throughout the United States within 60 days.

Now, if later on they decide they want to appeal or there are two conflicting circuit appeals and something else happens, you can either come back to Congress and ask them to do something in the interim, or you can go and change the regulations under the Administrative Procedure Act and make an accommodation to legal reality.

But I find it very offensive to me to find that the 11th circuit has decided to pay everybody in the 11th circuit and that people in absolutely the same circumstances in the 5th circuit are being denied their social security when they are paying exactly the same tax under the same circumstance.

I would like to jump to a point of the Commissioner of Social Security. Mr. Svahn is the most recent Commissioner of Social Security but recently he was appointed Under Secretary of Health and Human Services. I was the Under Secretary for nearly 3 years in the Johnson administration. I can tell you it is a full-time job and more so.

I think Congress should indicate its disaffection with the absence of a full-time Commissioner of Social Security and with the policy of permitting the Under Secretary to act as if he were also the Commissioner.

You had Mr. Simmons before you today. He is not the man responsible for the policy. It is Mr. Svahn who is responsible for the policy on disability. You didn't have the right man here that is accountable. As long as he is the Under Secretary with no Commissioner, I think you should call him. He should defend his actions.

He is the man who is making the policy under instructions from OMB, and I think the people who make the policy ought to be here in Congress to defend it, not somebody who is given instructions on what to say in answer to the questions and who really can't make any commitment to you as to what will be the future policy.

I urge you to consider inclusion of an amendment to any bill you report to preclude continuation of the present situation, or to handle this matter in your committee report.

I don't know how to resolve it, but I think that it is an intolerable situation and that is why this disability thing is in a big mess right now.

Section 704 of the Social Security Act requires the submittal and publication of an annual report by the Secretary on the administration of the act. This statutory requirement has not been complied with strictly in recent years.

I believe a full annual report on the program is needed and should be required by statute. In this way, Congress and the American people would have essential information needed for both legislative review of the appropriations process and for public education.

I urge your adoption of a special amendment to require this action so you know what you can count on when you come to the legislative action on the facts of the program. Very complex, very detailed, the process of the claims, the appeal time and the administrative cost and the reconsideration and the State agency role. You don't have that all down in a document that you can easily turn to. It is included in the record all the relevant material from the appropriation submittal of the Department this year, which I have here.

You made certain quotations. In order to answer many of the questions, when I wanted to find out, I had to go to the Appropriations Committee and tear it out of the appropriations analysis of what the administration is recommending. You can see what they are recommending and, in my opinion, why there isn't enough personnel and support for doing it. Obviously, the Appropriations Committee is not going to do much more than what the administration asks for, but a big mistake in the 1980 amendments is they didn't staff up big enough to do what you questioned them as to what they did. They started in March 1981 when they should have in March 1981 staffed up for 6 months to do what they were doing.

Mr. SHANNON. Mr. Cohen, that was certainly the intent of the Congress in 1980. That was pretty explicit in the report language. I think we all know that there were protestations made within the bureaucracies at the effort of the administration to try to accelerate these reviews. I don't think anybody in the administration can avoid responsibility for the result of their not staffing up.

Mr. COHEN. I have this suggestion which the chairman and you may not agree with, but in trying to struggle with this, I would repeal section 221(c) of the 1980 law, and eliminate the numbers game. I think the difficulty with section 221, the 15-35-65, 3-year-review plan, it gives Mr. Simmons the excuse he has had that he was doing exactly what Congress told him to do, and especially since the law says at least.

Mr. SHANNON. Which is baloney.

Mr. **Cohen**. I agree it is baloney, but the answer to the problem is to repeal 221(c) and put a different kind of concept in of review consistent with adequate staffing appropriations and the submittal of lead time material which will be submitted to the Ways and Means Committee, consistent with the recent Supreme Court decision, at least you ought to have a look at it before it goes into effect. I don't know whether 65 percent is the right number. And I don't think you do. And I don't think anybody on your staff knows whether it is 45 or 65 or 85. And so I would like to eliminate the numbers game.

I said if there were enough staff and everything, I would review everybody once a year, if you talk about a conceptual framework, of what is desirable in disability. That doesn't mean that everybody would have to be reexamined with medical evidence and so on. But at least bring the case up, if the fellow was 55 and over, and there had been no medical improvement, just pass it by.

But the concept of complete review, using the term review in a more general sense, is certainly sound in the program. And then you would use, as Mr. Simmons said so well, common sense, in deciding what groups would have certain criteria for reexamination, and which would not. And—if you ask me a question, I will tell you my answer about what I think those criteria would be. But I would rather see now after what has happened, take the numbers game out of the law and insert in lieu thereof some other more appropriate provision.

On the SSI disability, Mr. Chairman, we urged and supported section 405 of the 1983 amendments which provided for notification to all OASDI recipients of the availability of SSI benefits. However, we believe there was a defect in the law, that it does not include the blind and disabled. And we strongly urge you in this bill, to amend the existing law to include the blind and disabled within that amendment.

I think that was the intent, at least that was the intent when Mr. Fleming and I testified over in the Senate, which we thought Senator Dole accepted.

Somewhere along the line on several occasions, Congress has taken action too broadly and too quickly without due regard to the technical administrative and personnel implications of social security disability.

Social security is a very big program, Mr. Shannon. It has 36 million beneficiaries, drawing benefits every month. Let me tell you, if that check is not there on the third of the month, when I was Secretary and when Mr. Driver was Commissioner, I would get telephone calls, and Congressmen would get telephone calls. And all you had to do is lose one mail bag in your district, and you would get a lot of telephone calls.

Mr. **Shannon**. One check.

Mr. **Cohen**. One check.

It needs careful, sensitive and planned treatment. You can no longer make amendments to the Social Security Act that the President signs on Friday afternoon, and put them into effect on Monday morning. It is not that kind of a program. It may well have been in the early days, 1939, when we passed the 1939 law and made the amendments effective. But that is not true anymore.

You have to give enough lead time to train the personnel to implement the policy. And I am against what the administration has been doing, like in the medicaid program, making a basic change in policy through the manual.

I never heard of such a thing when I was Secretary, to basically change the program of medicaid, I am talking about, through the manual.

That is no way to do business in my opinion.

Now, we want to require all steps to follow the Administrative Procedure Act, and all be in the Federal Register, that is a different kind of question. I personally would be for any Commissioner's rulings being printed and being distributed widely and so on, possibly without initially having to go through the same detail of the Administrative Procedure Act, or I would suggest that you modify the Administrative Procedure Act in relation to the Commissioner's rulings in order to get the stuff out very promptly, and then have them put into the regulations in accordance with the Administrative Procedure Act.

We need prompt action, but also effective and compassionate action.

It is more efficient to eat all three meals at once and save the time, effort and dishwashing, but it has the disadvantage of indigestion. We now have disability indigestion from the actions and inactions of both Congress and the administration. So I say be wise and careful at the same time in what amendments you propose, and I would say this, Mr. Shannon, in connection with your bill, don't make all the amendments in your bill effective on the same day. That is indigestion.

I mean, space them out so that social security can handle them, with due staffing time, with due budgeting, and all of those factors.

And please give us some adequate opportunity to comment on your proposed recommendations. I am authorized to say that Secretary Fleming is in full accord with the views I have expressed in this statement. I know there are many complex questions with which you are concerned—both Mr. Driver and I will be willing to answer your questions. We have comments to make on the face-to-face hearing. We have comments to make on other matters if you wish to inquire of us.

Mr. SHANNON. Mr. Cohen, I am going to run and vote. I will be back in 5 minutes.

Mr. COHEN. Perhaps, Mr. Pickle, you might like to inquire about two things I said that were in answer to your questions earlier.

I commented——

Chairman PICKLE. I have already got posted on one of them. That is on the rulings and regulations—but you don't maintain some of the rulings. I am a little surprised at that.

Mr. COHEN. Not quite, sir. Let me explain that.

I thought your question had to do as to whether the commissioner's rulings should be automatically included in the regulations periodically. That is the way I understood your question.

Chairman PICKLE. Well, I don't know that I intended it maybe that broad, but almost.

Mr. COHEN. I was making this comment.

I am strongly in favor of first publishing any Commissioner's rulings in the Federal Register and pursuant to the Administrative Procedure Act. In other words, Mr. Simmons' point is they may be voluminous and take a lot of time, and they could not get the regulations issued quickly. My answer to that is publish them, make them available on the next day, and then include them in the regulations as soon as feasible.

Chairman PICKLE. How can various groups make comments about it?

Mr. COHEN. Well, I think what I would do, I would pass an amendment in your bill that on any commissioner's rulings, individuals would have 60 days on which to comment on them, and the Commissioner, the Secretary, must take those into account and make a report at a subsequent time. But I am trying to answer Mr. Simmons, who says, "Oh, we cannot get them all in the regulations. They would be very big and so on." My point is since the Commissioner's ruling is the one that is binding on the staff, get it out, and then allow people to comment on them, and if you authorize in the law that they have a period of time to do that, that would not affect the policy in the interim, but at the same time would give the groups the information, and at the same time wouldn't halt the Administrative Procedure Act process.

Now, my other point that I made was, sir, I am in favor of the repeal of the 15–35–65 numbers in your 1980 law. I think that now that in effect that has passed, and we have all this excitement, I would eliminate the concentration on the numbers game, which causes us all to say, "You are at fault and I am at fault and he is at fault," and I would substitute a different kind of concept in there, Mr. Pickle.

I would substitute a concept which said, as much as I can think it out, something like this: "The Secretary shall take the necessary steps to provide for periodic reexamination of individuals on the rolls, taking into account certain criteria, like you have delineated, in order to insure that individuals who are bona fide disabled shall continue and those who are not shall—"et cetera, et cetera.

In other words, don't put the emphasis on 65 percent. I don't know whether that is the right figure or not.

Chairman PICKLE. None of us do, but the law previously on the general review was they shall make these periodic reviews to determine if people are able or disabled. Yet, the HHS was not doing it. Very little. If you don't have some number——

Mr. COHEN. I would have no objection to your putting some minimum in. But I am trying to say that I think we have gone into a numbers game which I find rather unfortunate.

Chairman PICKLE. A minimum number might be——

Mr. COHEN. I don't want to blame the administration. Those people who are doing this job are very conscientious people. They are trying to do a good job. They are hemmed in by the OMB, the demand to cut benefits. They have the administrative law judges on their necks. They have the State agencies on their necks also. And they have thousands of complaints coming in the office. It is the most difficult job in the Federal Government outside of being a Congressman.

So I really think that we ought to try to find an alternative way of getting at the same result that you want, but in a more objective and less numbers game proposition.

Chairman **Pickle**. Mr. Secretary, let me ask you one or two questions that we asked of the administration earlier.

Senator Heinz had placed an amendment over in the Senate with respect to the supplemental appropriations bill, a 6-month moratorium, in cases involving mental impairment. What is your view about a moratorium in that respect?

Mr. **Cohen**. First, let me say, Mr. Chairman, I personally am opposed to riders on appropriations bills. I always have been when I was in the government. I don't think that is the way to legislate.

Second, I think the moratorium, while it has certain desirable aspects, should be part of a larger treatment of the basic defects. A moratorium is necessary for *x* period of time to enable the new criteria to be developed. I don't know right this minute how long that is. Mr. Simmons didn't answer that question this morning. He said, "Well——"

Chairman **Pickle**. Until we could agree on the standards.

Mr. **Cohen**. Yes, until we agree on this or that. Well, I would have a moratorium until that occurred. But I would certainly put the heat under the Administration to come up with the criteria. But I personally am not in favor of doing it on an appropriations bill. I have always been opposed to that. I don't think that is the way for Congress to legislate policy.

Chairman **Pickle**. What do you or your group feel about face-to-face hearings?

Mr. **Cohen**. Mr. Driver is going to answer that question, because he has had experience with that, as he was the Veterans' Administrator as you know. He studied that very extensively.

Chairman **Pickle**. Mr. Driver.

Mr. **Driver**. Thank you, Mr. Chairman.

Face to face is a built-in guaranteed right in the VA program, which is similar to the social security program, and for that reason I was amazed to get to social security and find it was not present. I was also amazed to find that it was possible only to have the face to face if you stood up and demanded it at the ALJ level. It seems to me this is a total absence of due process. It not only guarantees that there will be the appearance of not getting a fair shake, but it might go a long way toward helping, as a matter of fact, make certain that you don't.

I don't think a person should decide a claimant's case involving a 100 percent disability, certainly, that may mean the difference between economic security an total lack of it to him and his family, her and her family, and not have the opportunity for a face-to-face appearance by the first decisionmaker who says no. Therefore, I believe that should be in the system, and when I was the Commissioner of Social Security, we did have a project in place to go ahead and test that, and there were five or six other things.

Chairman **Pickle**. At what level would be the first meeting with a decisionmaker?

Mr. **Driver**. The first place would be the State level actually. I would probably compromise at the recon level. But I think indeed you have to recognize it is a compromise.

In my opinion, the claimant at the claimant's option should have the right of appearance at any level—period. If it means that the claimant has to travel 200 miles to see the person to present himself or herself, that is fine, that is the decision that the claimant makes. But to say that they don't have the right to appear, I think is a denial of justice.

Chairman PICKLE. Would you express an opinion about face-to-face hearings at the initial stage?

Mr. DRIVER. I would do it. I would make it possible.

Chairman PICKLE. If you would do that at the initial level, and Secretary Cohen testified whatever we do, enough money, personnel, and lead time—suppose we did go to the initial level. How much lead time would be a reasonable lead time?

Mr. DRIVER. In order to implement this idea?

Chairman PICKLE. Yes.

Mr. DRIVER. I would think that you in some cases probably need as much as 6 months.

Mr. COHEN. Mr. Driver and I talked about that this morning. I think that if you were to make it possible at the option of the complainant, and also at the option of the administrative agency, both of them, and continue the reconsideration level, which I would recommend myself—I am personally in favor of continuing the reconsideration which is a separate issue—I would argue for between 6 and 12 months, because I am more conservative on that aspect.

Chairman PICKLE. What would either one of you feel about a course of action, if a State had some hesitancy of doing this, or had some objection, or was balking about it, what course of action would you take? First of all, the Secretary this morning, Mr. Simmons and Mr. Hays both waffled a bit on that. They said they wouldn't believe that would be a problem. But they never said it would not be.

Mr. COHEN. May I say two things, one thing in particular before I answer it. I think the problem is the same from Dr. Cotman in Michigan as we have in Texas, where you have great distances. I think if Delaware and Utah didn't want to do it, that would be a problem. I think I would require it as a Federal requirement, if I were the Secretary, for a State that had small enough size that they could not argue they couldn't do it.

In Michigan, to go from Marguette to Lansing, that is about 500 miles, I think you—he would either have to establish a couple of regional local offices, and so you would need to staff that up, so that I would say I would try to make the face-to-face hearing as convenient to the claimant as possible but not more than 150 miles. I would do as Mr. Driver said, I would make it at the option of the claimant, and if he was willing to do it, fine, if he wasn't, it would be his or her decision.

But I don't think you could say that a person in Lubbock had to come to Austin for the face-to-face hearing. So I think that that is why I favor allowing a little more time, giving a little more money, setting up the regional local offices convenient to the claimant.

Chairman PICKLE. Particularly my State would have to have regional offices.

You could not make it any more difficult than it is under a normal hearing now.

Mr. **Cotman**. I would like to concur on the importance of there being face-to-face contact. The question which has not been addressed and I think should be considered by Congress is the location of whether it should exist and take place within the context of the State agency or in the context conversely of the social security district office.

Secretary Cohen has addressed the question of distance. In most instances, the claims have been filed in the social security district office, and in most States, the disability office is located in either the capitol or in a very few number of decentralized offices. So the prime location for that type of face-to-face contact, it seems to me, because of its proximity to the client and therefore not creating an inconvenience in terms of travel for those who might not be able to do so, might well be the social security office where they initiated their first claim.

So I am speaking then in favor of the need for a face-to-face contact which can enhance the decision. And second, a recognition that the site of that face-to-face contact is of equal importance in view of its possible dilaterious impact on the clients.

Chairman **Pickle**. Do either of you gentlemen, Mr. Driver, Mr. Cotman, want to make additional statements over and above what Secretary Cohen has submitted as testimony? I don't want to not receive anything.

Mr. **Driver**. No, sir. I don't.

Chairman **Pickle**. In view of the fact that we had some sparring this morning with HHS, social security people, we may be submitting to you and your organization questions for specific response. I am hoping that we can come together on some of the issues.

Mr. **Cohen**. I would like to ask your permission that these two brief chapters on disability and the appeals process from the National Commission on Social Security be inserted in the record. As you will remember, I was an appointee of the Speaker to that Commission which preceded the Greenspan Commission. There are two chapters in there that deal with disability and the appeals process which I think you may have forgotten by now. So it may well be.

Chairman **Pickle**. Glad to be reminded about it. I thank you for it.

[The information follows:]

CHAPTER 9—DISABILITY PROGRAMS

The Disability Insurance and the Supplemental Security Income (SSI) disability programs are designed to provide benefits to people who have severe long-term disabilities. Disability Insurance is part of the Social Security program. It pays benefits to disabled workers and their families based on the worker's past earnings. The SSI program pays benefits, based on proven need, to low-income disabled and blind people. In November 1980, $1.3 billion in Disability Insurance benefits were paid to 2.9 million disabled workers and 1.8 million spouses and children. The average monthly benefit for disabled workers was $371, not including family benefits paid to children and spouses. The Federal SSI program in October 1980 paid $.35 billion to 2.1 million disabled and blind recipients. For about 1 in 3 of these recipients, the SSI payment supplemented small Disability Insurance benefits.

The Commission believes that the Disability Insurance and the SSI disability programs are basically sound in structure, but need some modification and modernization. The Commission's review of the disability programs focused on:

(1) The definition of disability;
(2) The cost of the Disability Insurance program;
(3) Provisions to encourage a return to work;

(4) Benefit levels;
(5) The administrative structure; and
(6) The disability determination process.

DEFINITION OF DISABILITY

To be considered disabled under either the Disability Insurance or the SSI program, a person must be "unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that has lasted or is expected to last 12 months or to result in death." An individual's physical or mental impairment(s) must be ". . . of such severity that he is not only unable to do his previous work but cannot, considering his age, education and work experience, engage in any kind of substantial gainful activity which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work."[1]

To qualify for disability benefits, a person must have a severe impairment or combination of impairments. In practice, some types of impairments are so severe that they are presumed to constitute a disability if the applicant is not, in fact, working.

Other severe impairments or combinations of impairments are considered a disability only if, after assessing the applicant's remaining physical and mental capacities and his or her age, education and work experience, the person is found unable to work. Inability to work, in these cases, means inability to meet the demands of the applicant's past work or of a significant number of less demanding jobs in the national economy, and little or no potential for adapting to a new job.

Age is an important consideration in these cases. Under regulations that govern the application of the test of disability, standards for determining whether an impairment constitutes a disability become less stringent at progressively older ages. For example, workers 60 or older are more likely than workers under 50 to be found disabled if they are unable to continue their usual work.

The definiton in the law distinguishes between an impairment and a disability. An impairment is a physical or mental condition determined by a physician. Disability is the inability to work[2] because of the impairment. Disability is a social concept, not just a medical one. Whether or not people are disabled depends on their capacity to work in spite of their impairments and this capacity depends, in large part, on their age, the kind of work they have done, and what they can be trained to do in the future. The determination of whether an impairment constitutes a disability is a matter of judgment based on the vocational as well as the medical evidence available.

Compared to other domestic disability programs and most foreign social insurance programs, the definition of disability in the Social Security law is very strict. Partial disability, as recognized in the Veteran's Administration program and many government programs, is not sufficient. Nor is it enough that applicants can no longer perform the jobs they have held. If they can perform other jobs available anywhere in the Nation, not just in their own labor market areas, the definition rules out the payment of disability benefits.[A]

The historical trend in disability rates is shown in Table 9-1. During the early years of the program, disability award rates (disability benefit awards as a percent of those insured for disability benefits) were relatively high. This is because only those age 50 or older were eligible for disability benefits and the incidence of health problems among this age group is relatively high. When workers below 50 years of age became eligible, the award rate dropped.

Between 1965 and 1970, Disability Insurance award rates fluctuated in response to legislative changes which both modified the definition of disability and expanded the insured population. During the first half of the 1970's, the award rate grew by almost 50 percent. This rapid growth has been attributed to more attractive benefit levels, a high rate of unemployment, and an apparent increase in the social acceptance of government benefits.[3] The increase in awards during the 1970's has also been linked to the administration of the program and the multi-step appeals process.[4] In 1968, only 9 percent of all the people awarded DI benefits received them through the appeals process after initially being denied benefits. By 1978, this rose to 26 percent.

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[1] Sections 223 and 1614 of the Social Security Act.

[2] Work is defined as "substantial gainful activity" and is measured by the dollar amount of the person's actual or potential earnings (see page 200).

[A] By Mr. Cohen, Mr. Dillman, Ms. Duskin, and Ms. Miller: We believe that further consideration should be given to repeal of the national economy test and to adoption of an occupational test for Disability Insurance benefits after age 55 or 60.

[3] Bayo, Francisco R., Stephen C. Goss, and Samuel S. Weissman, Experience of Disabled-Worker Benefits under OASDI—1972-76, Actuarial Study No. 75, Social Security Administration, June 1978, pp. 3-4.

TABLE 9-1.—NUMBER OF AWARDS AND INCIDENCE RATES FOR DISABLED WORKER BENEFICIARIES, 1957-80 [1]

	Number insured on January 1 (in millions)	Number of awards during the year (in thousands)	Incidence rate (per thousand)
Calendar year:			
1957	10.00	179	17.90
1958 [2]	10.36	131	13.79
1959 [2]	11.78	178	13.95
1960	46.36	208	4.49
1961	48.51	280	5.77
1962	50.47	251	4.97
1963	51.52	224	4.35
1964	52.30	208	3.98
1965	53.32	253	4.74
1966	54.99	278	5.06
1967	55.72	301	5.40
1968	67.96	323	4.75
1969	70.12	345	4.92
1970	72.36	350	4.84
1971	74.50	416	5.58
1972	76.14	455	5.98
1973	77.80	492	6.32
1974	80.44	536	6.66
1975	83.27	592	7.11
1976	85.15	552	6.48
1977	86.65	569	6.57
1978	88.83	457	5.15
1979	90.60	409	4.51
1980 [3]	93.10	390	4.19

[1] From Actuarial Study No. 81, Social Security Administration, April 1980.

[2] For statistical purposes, the years 1958 and 1959 were defined as covering the periods Jan. 1, 1958 to Nov. 30, 1958 and Dec. 1, 1958 to Dec. 31, 1959, respectively. However, the gross incidence rates are shown after conversion to an annual basis.

[3] Estimated by the Office of the Actuary, Social Security Administration.

Since 1975, Disability Insurance award rates have dropped significantly. The estimated rate for 1980 is 4.19 awards per thousand insured workers—one of the lowest in the history of the program. This decline in the award rate can be attributed to more intensive review of claims, more claims being denied, and the changing age structure of the working population as more younger workers with low disability rates are entering the work force.

The Commission finds little evidence that the definition of disability in the law is too liberal or that it allows benefits to be paid to people who are able to work to support themselves.

COST OF THE DISABILITY INSURANCE PROGRAM

The cost of the Disability Insurance program has been a source of concern during the decade of the 70's. The projected long-range cost (benefits as a percent of taxable payroll over the next 75 years) fluctuated greatly due both to an increase in award rates that peaked in mid-decade and to a problem in the benefit computation that was corrected by the 1977 Amendments to the Social Security Act. The projected long-range cost rose dramatically from 1.18 percent of taxable payroll in 1972 to a high of 3.68 percent before enactment of the 1977 Amendments. Those Amendments lowered the future cost of both the disability and the retirement benefits programs.

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[4] Schobel, Bruce D., Experience of the Disabled-Worker Benefits under OASDI—1974-78, Actuarial Study No. 81, Social Security Administration, April 1980, p. 6.

Disability award rates have also declined sinced mid-decade. The long-range future cost of the Disability Insurance program is now projected to be about 1.5 percent of taxable payroll.

PROVISIONS TO ENCOURAGE WORK EFFORT

The Commission believes that the Disability Insurance and the SSI disability programs should be designed to enable and encourage the disabled to return to work. This enhances the individual's sense of self-worth and, to the extent that the disabled regain the ability to support themselves, it reduces the cost of the disability benefit programs.

At the same time, the Commission recognizes that most disability beneficiaries are not likely to regain sufficient earning capacity to support themselves and their families because the test of disability in both the Disability Insurance and the SSI disability program is such that only those with severe long-term impairments are considered disabled.

Those receiving Disability Insurance benefits tend to be older workers; 73 percent of those on the Disability Insurance rolls at the end of 1977 were over the age of 50; 58 percent were over the age of 55.[5] Many have progressive impairments that are not likely to be reversed. Many have limited educations and job skills and few prospects for transferring to new occupations before retirement age.

SSI disability recipients tend to be a younger group, some of whom have never had sufficient earnings to support themselves. Some have had severe mental or physical impairments since birth.

While the Commission recognizes that many of the disabled are not likely to become fully self-supporting, it believes that the benefit programs should be designed in a way that encourages those who can regain the capacity to support themselves to do so and that allows those with severe limitations to fully utilize their potential, however great or limited it may be.

Three features of the current disability program affect beneficiaries who return to work. They are the definition of substantial gainful activity (SGA), the trial work provisions, and Medicare.

Substantial gainful activity, as defined in regulations, is work which involves significant physical and/or mental duties for remuneration or profit, and is measured by the dollar amount of actual or potential earnings. Benefits are terminated either when the beneficiary's condition improves to such a degree that it can be assumed that he or she has regained the capacity to perform such activity, or when earnings from work performed while collecting benefits demonstrates a capacity to engage in substantial gainful activity regardless of the severity of the impairment. If an individual earns $190 or less a month, he or she is not ordinarily considered to be engaging in substantial gainful activity. If monthly earnings are $300 or more, he or she is not considered to be disabled.[6] When monthly earnings fall between these two amounts, the SGA determination is based on other aspects of the work performed.

In order to encourage beneficiaries to test their caacity to work without risking the immediate loss of benefits, a "trial work period" provision was added to the law in 1960. Its purpose is to permit beneficiaries to work long enough to test their ability to work. It extends for 9 (not necessarily consecutive) months during which a beneficiary whose impairment has not medically improved can receive earnings from work performed on a trial basis and continue to get full benefits. (Any month in which earnings are less than $75 is not counted as part of the trial work period.) If the beneficiary is engaging in substantial gainful activity (that is, earning $300 or more a month) by the end of the 9 months, cash benefits are paid for an additional 3-month "grace" period and then are stopped. During the next 12 consecutive months, the beneficiary can start receiving benefits again if monthly earnings fall below the substantial gainful activity level. (Table 9-2 gives the history of substantial gainful activity levels and dollar amounts used to determine a month of trial work.)

Disabled workers are entitled to Medicare benefits after a 24-month waiting period from their first entitlement to cash benefits. Usually Medicare entitlement ends at the same time to cash benefits cease. However, for the beneficiary who has not medically recovered but returns to work, Medicare entitlement extends for an additional 36 months after cash benefits cease and there is no second waiting period for Medicare if the person becomes re-entitled to worker benefits within 60 months.

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[5] Social Security Bulletin, Annual Statistical Supplement, 1977–79, table 65, p. 110.

[6] These SGA dollar amounts are based on regulations in effect in calendar year 1980.

Recovery rates increased during the 1960's after the trial work period was introduced, and after workers under 50 became eligible for disability benefits. The rates subsequently declined steadily unitl 1977, when they once again began to increase (see Table 9-3).

It was theorized at that time that people be more likely to go back to work if the SGA level were higher. It has also been suggested that an extension of the trial period may be a greater incentive for a beneficiary to return to work than the dollar level of substantial gainful activity.[7] Congress responded to this suggestion in 1980 by adding the 12-month automatic re-entitlement period to the original 9-month trial work period plus the 3-month grace period. The National Commission recommends that this incentive be strengthened by raising the substantial gainful activity level to the earnings test exempt amount applied to beneficiaries who are below the age of 65. Earnings below this amount would not be considered substantial gainful activity. This would increase the amount used to define SGA to $340 a month in 1981, define it in statute rather than in regulation, and subject it to the same automatic indexing procedures as the earnings test. The Commission recommends that the amount used to define a month of trail work, currently $75, be indexed in the same way as the earning test.

TABLE 9-2.—SUBSTANTIAL GAINFUL ACTIVITY LEVELS AND DOLLAR AMOUNTS USED TO DETERMINE MONTH OF TRIAL WORK

	SGA levels for the disabled [1]		Amount to determine trial work period
	Lower limit	Upper limit	
Year:			
1958	$50	$100	Any amount triggers a month.
1966	75	125	
1968	90	140	Monthly earnings of $50 or more triggers a trial work month (December 12, 1968).
1974	130	200	
1976	150	230	
1977	160	240	
1978	170	260	
1979	180	280	Monthly earnings of $75 or more triggers a trial work month.
1980	190	300	
1981	([2])	([2])	
1982	([2])	([2])	

[1] Different SGA levels apply to the blind.
[2] These amounts will remain at 1980 levels unless regulations changing them are issued.

TABLE 9-3.—TERMINATION RATES FOR DISABLED WORKER BENEFICIARIES, 1957-79 [1]

	Average number of beneficiaries on the rolls (in thousands)	Termination rates (per thousand)	
		Recovery	Death
Calendar year:			
1957	81	0.6	110.1
1958 [2]	201	7.6	152.2
1959 [2]	289	10.3	136.7
1960	[3] 397	7.9	109.6
1961	540	5.4	112.1
1962	684	14.0	97.9
1963	790	16.4	92.9
1964	867	19.0	87.5
1965	948	19.4	84.2

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[7] Franklin, Paula, "Impact of Substantial Gainful Activity Level on Disability Beneficiary Work Patterns," Social Security Bulletin, March 1976.

TABLE 9-3.—TERMINATION RATES FOR DISABLED WORKER BENEFICIARIES, 1957-79 [1]—Continued

	Average number of beneficiaries on the rolls (in thousands)	Termination rates (per thousand)	
		Recovery	Death
1966	1,053	21.9	80.1
1967	1,159	32.1	79.5
1968	1,259	30.0	79.4
1969	1,360	28.0	79.9
1970	1,460	27.9	72.5
1971	1,586	27.1	69.3
1972	1,754	22.5	62.0
1973	1,937	18.9	64.8
1974	2,129	[4] 17.8	63.4
1975	2,391	[4] 16.3	58.5
1976	2,615	[4] 15.3	52.5
1977	2,781	[4] 21.6	50.1
1978	2,882	22.3	48.8
1979	2,893	25.0	49.4

[1] From data in Actuarial Study No. 81, Social Security Administration, April 1980.

[2] For statistical purposes, the years 1958 and 1959 were defined as covering the periods Jan. 1, 1958 to Nov. 30, 1958 and Dec. 1, 1958 to Dec. 31, 1959, respectively. However, the gross termination rates are shown after conversion to an annual basis.

[3] This figure has been adjusted to take into account the elimination of the age-50 limitation during the year.

[4] From September 1974 through June 1977, procedures for identifying recovery terminations were defective. Numbers of recovery terminations have been estimated for 1974-77 on the basis of data from other sources.

The estimated cost of this proposal is:

Additional DI benefit payments in calendar years:	*Billions*
1981	(1)
1982	(1)
1983	(1)
1984	$0.1
1985	$0.2
Long-Range cost effect (percent of taxable payroll)	+0.01

[1] Cost of less than $50,000,000.

The Commission is also recommending that the 24-month waiting period for Medicare entitlement be reduced to 12 months. This recommendation is discussed in Chapter 13.[B]

The work incentive issues surrounding the substantial gainful activity amount and the trial work period should be re-evaluated after the Social Security Administration completes the work incentive demonstration projects mandated by the 1980 Amendments. More needs to be learned about which provisions actually encourage and enable the disabled to work and how those provisions could be equitable and effectively implemented.[C]

DISABILITY BENEFIT LEVELS

The Commission believes that Disability Insurance benefits should, when combined with other income, provide a reasonable replacement of the worker's prior earnings. At the same time, benefits should not be so high as to deter the beneficiary from returning to work.

[B] By Mr. Cohen, Ms. Duskin, and Ms. Miller: We wish to point out that this still would mean a disabled person would not be eligible for medicare until the 18th month form the onset of disability (i.e., the 5 month initial waiting period plus 12 additional months). It is, therefore, essential that private health insurance coverage be automatically continued for this period for all persons who are subsequently determined to be disabled. Further, follow up studies should be undertaken to see how this revision works out in actual practice and whether any disabled persons lose health insurance coverage during the 17-month hiatus and any proposals to remedy the situation.

[C] By Mr. Cohen, Ms. Duskin, Ms. Miller, and Mr. Myers: We urge that consideration by given to varius earning-disregard offsets in relation to varying SGA income levels to evaluate their impact on work incentives and costs. It is suggested that such experiments be worked out with different voluntary associations of disabled persons and State agencies.

During the 1970's, DI benefits were criticized as being so high that they discouraged work. The average monthly benefit for workers in 1970 was $131. It rose gradually to $265 by December, 1977. Though this amount is not generous in absolute terms and it, in fact, low in relation to worker's most recent earnings, it may seem high when compared to average lifetime earnings. Average lifetime earnings, however, is not as appropriate a measure of the adequacy of benefits because it is usually lower than the most recent earnings—a better measure of the adequacy of benefits.

The basic disability benefit is computed in essentially the same way as the retirement benefit. Prior to the 1977 Amendments to the Social Security Act, the benefit computation procedure favored young disabled workers—in some cases by significant amounts. This was because the younger workers, with their shorter worklives, had fewer years of outdated earnings included in their average lifetime earnings. The 1977 Amendments changed this, by providing a new benefit formula based on indexed earnings.

A second way in which the benefit computation was thought to favor young disabled workers relates to the provision for allowing a worker's 5 years of lowest earnings to be dropped when lifetime earnings are averaged. These five dropout years represented a considerably larger portion of the total worklife for young disabled workers than for retired workers. The Social Security Disability Amendments of 1980 changed this provision so that the number of dropout years for young workers in more nearly proportional to the length of their worklives.[D]

A third way in which disability benefits were cited as discouraging work effort related to the availability of auxiliary benefits for children and spouses. Each eligible child is potentially eligible for 50 percent of the worker's basic benefit, and a spouse caring for the child(ren) is also eligible for 50 percent. The total payable to the family, however, is limited to a maximum amount. Until the 1980 Amendments, the maximum amount ranged from 150 percent of the worker's full benefit for those with a history of low earnings, up to 188 percent for those with moderate earnings and 175 percent at higher earnings levels. The 1980 Amendments provided a lower limit on family benefits. The law now limits family benefits to the lesser of 85 percent of the worker's Average Indexed Monthly Earnings, of 150 percent of the worker's full benefit.

The Commission believes thet the limit imposed by current law is too strict. It recommends that the monthly family maximum for disability be raised to 80 percent of the monthly average of the worker's highest 5 consecutive years of indexed earnings, or to the limits in effect prior to enactment of the 1980 Amendments, whichever is lower. The Commission believes this change is appropriate because the disabled, in general, have greater income needs than the rest of the population. Disabled workers with families incur the costs associated with child-rearing as well as higher personal care expenses. They rarely have the savings that older workers have accumulated. When they are prematurely separated from the work force, they forego not only their current earnings, but any future wage growth they might otherwise have achieved. The limit on disability family benefits recommended by the Commission is less restrictive than the one now in the law. It provides a reasonable replacement of prior earnings for those who have children to support and, at the same time, would assure that benefits are not excessive relative to past earnings.[E]

The estimated costs of this proposal are:

Additional DI benefit payments in calendar years:	*Billions*
1981	$0.1
1982	$0.2
1983	$0.3
1984	$0.4
1985	$0.5
Long-range cost effect (percent of taxable payroll)	+$0.06

[D] By Mr. Cohen, Ms. Duskin, and Ms. Miller: We opposed this change and would prefer to restore this provision in the law as it was prior to 1980. The change disadvantages the younger disabled worker who had not yet been able to reach his or her full earning capacity as a mature worker.

[E] See dissenting statement on liberalization of maximum family benefits for disabled workers by Mr. Laxson, Mr. MacNaughton, Mr. Myers, and Mr. Rodgers.

ADMINISTRATION OF THE DISABILITY PROGRAMS

The Disability Insurance and the Supplemental Security Income disability programs are administered under a unique Federal-State relationship. Program administration carried on by each State is paid for by the Federal government. Under agreements with the Secretary of Health and Human Service, State disability determination units (most are housed within State vocational rehabilitation agencies) make the disability determination based on the definition of disability in the Social Security Act, in accordance with Federal regulations and guidelines issued by the Social Security Administration. This arrangement was instituted because the States had had prior experience in administering various disability-related programs, and had established working relationships with the medical community. It was assumed that if the disability determination process took place within State rehabilitation agencies, disabled individuals could be more easily referred for rehabilitation.

The Federal government's primary function in program administration is to interpret the law and oversee its uniform implementation throughout the country. The Social Security Administration writes the rules and standards governing the program and evaluates, through review of sample cases, the disability determinations made by the State agencies. The Secretary of Health and Human Services has authority to reverse a State agency benefit award as well as a State agency disallowance.[8]

Recent reports by the General Accounting Office (GAO) and groups of outside experts have been critical of this Federal-State arrangement. They point to the lack of uniformity in the ways States make disability determinations. The GAO has suggested that the program be completely federalized.[9]

The Social Security Disability Amendments of 1980 require the Secretary to enter into new agreements with the States. These agreements will require States to follow performance standards, administrative requirements, and procedures issued by the Secretary of Health and Human Services. If a State's performance falls short of expectations, the Secretary will be able to assume responsibility for program administration. A State may also terminate administration on its own initiative.

The Commission believes that, in general, the Federal-State system is working well. Most States do a good job of disability determination, but there is room for improvement in the Federal-State relationship through a closer partnership between SSA and the States.

Many of the problems are at the Federal level. SSA should develop clearer lines of authority from State agencies to its regional and central offices. It should create direct lines of communication between those responsible for developing policy and those responsible for implementing it. These lines should be used to issue regulations, policy statements, and procedural directives which are clearly written and meaningfully interpreted. Once these are transmitted, the States should have their questions, observations, and requests for clarification promptly answered by SSA.

The performance standards and requirements for State agencies being developed as part of the New Federal-State agreements, provided for in the Social Security Disability Amendments of 1980, should be achievable and reflect well-integrated program priorities. Once they are established, State agencies should be encouraged to exchange ideas and program experience related to achieving them. The Social Security Administration should play a larger role in training State agency personnel, developing training guidelines, and designing personnel training programs.

The Commission believes that these changes can improve the administration of the disability programs, and are preferable to federalizing the disability determination process at this time. Had a completely Federal operation been adopted when the program began, it might have produced more uniform results, but to change now from Federal-State administration to a federally-run program would disrupt operations and cause delays and possibly errors in adjudicating claims. Valuable State agency personnel, experienced in claims processing, could be lost in the transition. Hiring and training additional Federal employees would ultimately increase administrative costs. There is no guarantee that a Federal operation would be superior. The evidence presented to the Commission suggests that SSA should not take on additional administrative responsibilities.

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[8] Prior to the 1980 Amendments, the Secretary did not have the power to reverse State Agency denials.

[9] Committee on Finance, U.S. Senate, Issues Related to Social Security Act Disability Programs, CP:96-23, 96th Congress, 1st Session, October 1979, p. 26.

THE DISABILITY DETERMINATION PROCESS

State agencies make three types of disability decisions: the initial decision; reconstruction of denied claims if the applicant requests it; and continuing review of the disability status of those receiving benefits.

An applicant who is not satisfied with the reconsideration decision by the State agency can ask for a hearing before an Administrative Law Judge (ALJ). Those who are not satisfied with the ALJ's decision may appeal their case to the Appeals Council and then to the Federal courts. (see Chapter 10).

The initial claims process of the State agencies has been criticized for its length, complexity, and the quality of decisions produced. The large number of requests for reconsideration and hearings and the high reversal rate (that is, the allowance of claims previously denied) at the hearings level have been a source of continuing concern. The following table shows 1980 estimates of allowance rates at different levels of the process.

Disability applications	1,250,000
Initial allowances by State agencies	300,000
Allowance rate (percent)	(24)
Applications for reconsideration	200,000
Allowances by State agencies	40,000
Allowance rate (percent)	(20)
Applications for ALJ hearings	100,000
Allowances by ALJs	50,000
Allowance rate (percent)	(50)

The high reversal rates after the initial decision have been attributed to:

(1) Inadequate documentation of the initial claim;

(2) The progressive nature of applicants' medical conditions;

(3) The nature of disability; and

(4) Different sets of rules governing different levels of the disability decisionmaking process.

The quality of the disability application taken by the Social Security District Office and of the initial determination made by the State agency are the foundation of an accurate and timely disability decision. The significant increase in the disability claims caseload during the 1970's made such decisions more difficult. The rising caseload was due to an increase in Disability Insurance claims and to the implementation of the SSI disability program in 1974. In 1970, there were about 868,000 Disability Insurance claims. By 1974, the number of DI claims rose to 1.3 million, not including the additional SSI claims. In 1980, there were 1.2 million DI claims, with SSI disability claims bringing the total to 1.9 million individuals who applied for either SSI or DI benefits.[10]

In the past, when caseloads were high, prompt disability decisions were sometimes given priority over obtaining extensive evidence documenting the claimant's condition. In recent years, there has been greater emphasis placed on developing evidence for each claim, on the system of quality assurance, and on more specific Federal guidelines for case documentation. Yet allowance rates at the hearings and appeals levels remain high.

State agencies and the District Offices of the Social Security Administration cooperate in processing disability claims. District Offices accept applications, document the claimant's history and sources of medical evidence, and make all the non-medical determinations associated with eligibility concerning insured status, work activity, income and earnings. The State agency then collects and evaluates the medical and vocational evidence and makes the disability determination. Although the District Office responsibilities are basically clerical, the accuracy and completeness of the information which it takes are crucial. Incomplete or vague information about the claimant's medical or work history can cause unnecessary delays in the development of evidence and may affect the final decision.

Historically, the District Office claims representative has been a generalist working on all types of claims. The Social Security Administration has experimented from time to time with various types of specialization. Since 1978, people who apply for disability benefits have been interviewed by employees who specialize in either Supplemental Security Income or Old-Age, Surviviors, and Disability Insurance, depending on the type of claim, or by two employees when an individual applies for both types of payments.[11]

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[10] In 1980, 400,000 of the total 2.3 million applicants were for both Disability Insurance and SSI disability benefits.

The complex nature of the disability programs requires a skilled interviewer who knows the kind of information needed. Discussions with the staff of the State agencies and with SSA employees indicate that interviews sometimes yield inadequate information. Sometimes this happens because the case is complex. Sometimes the interviewer, pressed by a large caseload, does not have enough time to do a thorough job. Occasionally, the claims representative is inadequately trained.

If better-trained interviewers were available to take only disability claims (for both Supplemental Security Income and Disability Insurance), the number of unsatisfactory and inadequately prepared claims forwarded from District Offices to State agencies could be reduced. The Commission recommends that the Social Security Administration train and use disability program specialists in each District Office. The Commission recommends that the budgetary and staffing restrictions that have been imposed on SSA be relaxed to the degree necessary to allow this.[12]

Some have suggested that the high rate of allowances after initial denials can also be attributed to the progressive nature of the applicants' impairments. As noted earlier, many Disability Insurance applicants are older people who suffer from some chronic disease. When an applicant with a progressive disease is denied benefits at the initial level because the condition was not severe enough to be considered disabling, it is possible that by the time the case reaches the hearings level, the condition will have deteriorated.

Some have also suggested that the disability concept itself may contribute to the high allowance rate at the hearings level. To reach a finding that an applicant is or is not disabled requires a judgment about the effect of the person's impairment on his or her ability to work. While Federal regulations attempt to clarify the definition, they may be interpreted differently by different individuals.

The high allowance rate at the hearings level is also due, in part, to the fact that different levels of the adjudication process are governed by different sets of rules. State agencies must make their initial and reconsideration decisions according to the law and the SSA regulations and guidelines, as explained in the SSA claims manual. The reconsideration process results in few reversals of the initial decision because both decisions are governed by identical rules. An Administrative Law Judge at the hearings level, however, is prohibited from using these guidelines.[13] The adjudication process would be greatly strengthened by a single set of rules. The Commission believes that the administrative guidelines which bind the States should be published in regulations so that they govern the hearings decision as well. This should help provide more consistent disability determinations from one level of adjudication to another.

CHAPTER 10—SOCIAL SECURITY APPEALS

When applicants for Social Security and SSI[1] benefits are not satisfied with the initial decision on their claims, they may request a reconsideration by the agency that made the initial decision: the State agency in disability cases;[2] the Social Security Administration in all other cases. The case is reviewed by a person who did not participate in the original decision. Applicants who are dissatisfied with the reconsideration decision are entitled to a hearing before an Administrative Law Judge (ALJ). A large majority of all hearings concern claims for disability benefits.

At that hearing, the Administrative Law Judge is obligated to protect the interests of both applicant and government and has authority to uphold, modify or reverse the claim denial. If the denial is upheld, the case may then be reviewed, at the applicant's request, by the Appeals Council, an independent review group attached to the Office of Hearings and Appeals of the Social Security Administration. If the

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[11] When the decision to use specialized claims representatives was made, consideration was given to specialization according to disability and non-disability cases. It was decided that the Supplemental Security Income/Old-Age, Survivors, and Disability Insurance separation promised better operations than a disability programs/retirement programs specialization.

[12] See chapter 14 for a more complete discussion of the staffing and budgetary needs of the Social Security Administration.

[13] Under the Administrative Procedures Act an Administrative Law Judge cannot use the Federal guidelines issued to State agencies. This is done to protect the independence of the appeals process from the administration of the program.

[1] This description applies to OASDI and SSI claims. Appeals under the medicare hospital insurance program are discussed in chapter 13. The Commission has no recommendations concerning Medicaid appeals.

[2] For a description of the role of the State agency in the disability adjudication process, see chapter 9.

Council upholds the Administrative Law Judge's decision, or refuses to review the case, the applicant may request judicial review in a U.S. District Court.

Federal court decisions are based solely on the factual record developed at the earlier stages. The courts may affirm, modify, or reverse the earlier decision or send it back to the ALJ or the Appeals Council for further consideration. About one-half of district court cases are remanded to the Social Security Administration. The effect of such a remand is usually a finding in favor of the applicant.

In the course of its work, the Commission became concerned about the way the appeals process works in practice and the burden it places on applicants. Many appeals might have been avoided had the claims for disability, in particular, been better developed prior to the hearings stage. The Commission is recommending a change which it hopes will improve this by increasing the number of specialized personnel.[3] However, even if this is done, significant numbers of claims denials and benefit reductions will still be appealed. The Commission recognizes that many claimants have degenerative diseases that may have worsened by the time their claims reach the hearings level. As a result, it is expected that some claims will be allowed by ALJs, even when there has been adequate development at the initial stages. The Commission, therefore, recommends changes in the appeals process designed to improve the development of evidence prior to hearings, to encourage the development of a uniform body of precedential materials, and to improve the quality of hearings decisions generally.

PRE-HEARING CONFERENCES FOR DISABILITY APPLICANTS

The Commission recommends that ALJs or their designees be required to hold a pre-hearing conference with the claimant if the claimant requests it and is represented. Improved development of the case before the hearing can reduce the number of cases in which a full hearing will be needed and can expedite proceedings in others.[4]

Under present practices, Administrative Law Judges frequently base decisions on medical evidence developed at or after the hearing or on their own evaluation of the applicant's condition at the hearing. The Commission believes that better pre-hearing development of the evidence can expedite the adjudication process by insuring that medical issues are fully documented before the hearing date. A few Administrative Law Judges do have conferences with claimants and their representatives before the hearing. This practice should be mandatory when the applicant requests it.

The Commission cautions that pre-hearing interviews are inappropriate when the applicant is not represented. Unrepresented applicants may be intimidated at a conference into withdrawing a valid claim before the hearing itself, or fail to understand that they may be required to attend a full hearing at a later date.

CONSULTATIVE EXAMINATIONS FOR DISABILITY APPLICANTS

The Commission recommends that disability applicants be informed of their right to have treating physicians comment on the findings of consultative examinations. Consultative examinations can be requested by the State agency which makes the initial disability determination, by the Administrative Law Judge, or by the Appeals Council. They are made by physicians who have had no prior contact with the applicant. The Commission believes that when a consultative examination is ordered, applicants should always be informed in writing that they have the right to request that the comments of their treating physicians on the findings of the examination be solicited by the government. Where an applicant may have been treated by more than one physician for the condition for which the consultative examination was ordered, it is appropriate to contact them all. Physicians should be encouraged to meet the request even though their response is voluntary.[5]

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[3] See page 214, Chapter 9.

[4] Mashaw, Jerry L., et. al., Social Security Hearings and Appeals, D.C. Heath and Company, Lexington, Massachusetts, 1978, p. 64. Mashaw concludes from random interviews with Administrative Law Judges that 10 percent of appealed claims might be approved on the record without further development, but that the Administrative Law Judges are unwilling to approve them without conferences with claimants. Also, see 1978 Report, Administrative Conference of the United States, Recommendation 78-2, Procedures for Determining Social Security Disability Claims.

[5] The Social Security Disability Amendments of 1980 (Public Law 96-265) authorize the Office of Hearings and Appeals to pay physicians and other potential sources of medical evidence for

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UNIFORM PRECEDENTS IN DISABILITY ADJUDICATIONS

The Commission recommends wider distribution of precedential materials. The Commission is concerned about the high percentage of appealed cases in which the courts have reversed Administrative Law Judges' decisions. The Social Security appeals process does not create a uniform body of precedent which can be applied in subsequent cases. On some disability-related issues, there is conflict among Circuit Courts of Appeal. A great deal of "operational" law at the initial stages of the disability adjudication process has never been codified in the form of regulations.[6]

A study by the National Center for Administrative Justice indicates that the need to develop a body of uniform precedents is greater than ever.[7] The study explains that: . . . the use of case-based precedents seems particularly appropriate in the disability area. The problems of judgment lie in applying necessarily general rules to complex facts. A sense of how that judgment should be exercised cannot be communicated effectively in abstract terms; concrete examples are essential.

The report points out that the Social Security Administration's Office of Hearings and Appeals does little to follow judicial precedents:

> This omission raises a delicate but fundamental question of both principle and practice: To what extent is a national administrative agency bound, legally or morally, to follow the holdings of regional Federal courts? Must it try to harmonize court law and agency law within each judicial jurisdiction, even at the price of regional variation in the administration of its program? Or must national uniformity at the administrative level be maintained, even at the expense of prolonged discordance between agency law and court law within judicial districts or circuits? The first might be called a policy of compliance; and the second, a policy of disregard. SSA, as we have seen, has pursued neither course with systematic devotion; it has adopted a mixed policy, or perhaps no policy.

The Center's report severely criticizes this failure to follow judicial precedents.

> Administrative disregard can be creully unfair to those parties (in our case, disability claimants) who stand to benefit from the unheeded court decisions, giving them a hard choice between burdensome litigation and the forfeiture of their court-declared rights. The end result is a double standard: one rule, the favorable court-made rule, ultimately comes to be applied to those persevering and resourceful enough to litigate, while another rule, the unfavorable agency rule, determines the fate of those, equally deserving but less determined, who do not go to court . . . The more serious objection to administrative noncompliance with court precendents is the unfairness in absolute terms of withholding from citizens the rights to which the courts have held them entitled, forcing them to pursue costly judicial remedies in order to cash those rights in.

A SOCIAL SECURITY COURT

In order to make the basic changes needed in the Social Security appeals process, the National Commission recommends the establishment of a special court to handle all Social Security appeals from decisions of Administrative Law Judges.[8]

The court envisaged by the Commission would take over the appellate functions now in the hands of the Appeals Council and the Federal District Courts. It would be structured like the current Tax Court in that judges would be appointed by the President for a fixed term, and the President would designate a chief judge to administer the court. There would be divisions of the court so that cases could be heard throughout the United States, and a review mechanism would be established so that decisions having policy implications could be reviewed by the Court en banc or by panels of judges.

Review before the court or one of its divisions could be sought by either the denied applicant or the government, and would be on the record of the hearing and

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information already in existence in cases where an application for Disability Insurance benefits is filed. (Payment authority was already available for information on SSI claims.) Because it is not clear that this provision will cover payment for comments by treating physicians requested after a consultative examination, the Commission suggests that payment authority be extended to cover such comments.

[6] See page 215.

[7] Mashaw, Jerry L. et al., *supra*, at 109–112.

[8] The Commission considered recommending establishment of a special disability court, but it appears that the problems in disability appeals occur as well in appeals for other benefits. Therefore, the Commission decided that the new court should be concerned with all Social Security matters rather than be limited to disability cases only. Once such a court is established, consideration should be given to including SSI and Medicare appeals within the court's jurisdiction.

the evidence before the ALJ. Appeals from decisions of the court could be made to the U.S. Circuit Courts of Appeal only on grounds of constitutionality or statutory interpretation. Where the appeal is sought by the government and the applicant has not been represented, a lawyer should be available to the applicant at public expense for the court proceeding.

This new court could make significant improvements in the appeals process. Because they reviewed only Social Security cases, judges of the court would acquire an expertise in the area that judges in Federal District Courts usually lack. By creating a uniform body of precedential material, the court's decisions would have significant effect on the earlier stages of the adjudicative process as well. With all appeals going to a single court, it could no longer be argued, as it is now, that the need for uniform nationwide decisions precludes using the sometimes conflicting decisions of the several circuit courts as binding precedents.

The bulk of the cases appealed would be decided, as now, on the basis of whether there is substantial evidence on the record to justify granting or denying benefits.

Establishment of a special court would also help lessen the congestion in the Federal courts. In the twelve-month period ending September 30, 1980, 7,716 Social Security and SSI cases were filed in Federal District Courts. During this same period, the courts remanded 3,429 cases to ALJs and to the Appeals Council.

QUALITY CONTROL

The Commission recommends that the Office of Hearings and Appeals take prompt and effective steps to improve the quality of the Administrative Law Judges' decisions. The law provides that the Appeals Council may, on its own motion, review ALJ decisions. While the Commission removes this authority from the Council, it believes that the Council should still be able to look at the broad trend of ALJ decisions to determine if they are timely, consistent by region, and accurate. This review authority could become a significant element of a quality control program. The Commission acknowledges that the size of the caseload probably makes comprehensive review impractical, but notes that sampling techniques based on Social Security account numbers have been developed which can serve as a fair selection method.

Establishment of a special court as recommended by the Commission should help to improve the whole decision-making process in the long run. However, a strong quality control program is also needed. The development of quality control techniques should not be postponed pending Congressional action establishing the Social Security Court.

Chairman PICKLE. I thank you for your testimony and your patience and understanding, Mr. Secretary. You have been very cooperative. It is also a pleasure to have you here, because your testimony is enjoyable and very worthwhile. We thank you.

Mr. COHEN. Thank you, Mr. Chairman.

Chairman PICKLE. Now, Mr. McGough. We want to thank you. I know your statement is more of a report. These gentlemen did have a meeting that started at 2 and they just will make that. So I thank you for your cooperation.

If you would proceed, Mr. McGough.

STATEMENT OF PETER J. McGOUGH, ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY BARRY TICE AND DR. BERYCE MacLENNAN

Mr. McGOUGH. Thank you very much. In starting, I would like to introduce on my left Mr. Barry Tice, who directs all of the work that the GAO does in the disability area. On my right is Dr. Beryce MacLennan, GAO's clinical psychologist who helped us on the studies we have done.

I have a statement that covers a number of items. I am going to read the introduction, and then skip over a good bit of the middle to save time.

We are pleased to be here today to discuss the Social Security Administration's efforts over the last 2 years in reexamining the continued eligibility of persons on the disability rolls. These reexaminations, mandated by the Social Security Disability Amendments of 1980, Public Law 96-265, are referred to as Continuing Disability Investigations or CDI's.

Since March 1981, SSA has conducted CDI's on over 900,000 beneficiaries, and almost 400,000 have been terminated. The current termination rate at the initial decision level is 44 percent.

These reviews have been the subject of significant publicity and nationwide attention. Congressional concern has been intense through hearings, legislation, and other oversight activities. We have responded to many congressional requests regarding these reviews over the last 18 months and have testified at several hearings.

SSA has taken several initiatives over the last year to improve the review process, and the Secretary of HHS recently announced a major reform package to further improve the process for the mentally impaired as well as the physically impaired.

My testimony today will focus on two issues—the problems with adjudicating persons with mental impairments, and the issue of a possible medical improvement standard for all CDI's.

I will briefly summarize the next section. GAO was involved early in the CDI process with a report that we issued in March of 1981. We had looked at social security's diary and re-examination process at that time for people who had disabilities with some potential for improvement. Social security was to schedule those people for re-examination, and to look for the medical improvement.

Our report showed that the system was not working. Many people who should have been diaried were not, and many people who were diaried were never called or re-examined, which led to the overall position that there were a number of people on the rolls who were probably no longer disabled, or were not meeting the criteria for disability.

Congressional concern over SSA's medical re-examinations and other inadequate review procedures led to the enactment of section 311 of the Social Security Disability Amendments of 1980. This section required that beginning January 1, 1982, SSA review, at least once every 3 years, the status of disabled beneficiaries whose disabilities have not been determined to be permanent. SSA began the reviews in April 1981.

Since our March 1981 report, our studies have focused on SSA's disability re-examination efforts and the high termination rate, which was in excess of 40 percent through 1981 and 1982.

I would like to talk a little bit about the problems we identified in our most recent study on the mental impairment cases. Our review revealed several weaknesses in SSA's and the States' Disability Determination Services [DDS's] adjudicative policies and practices. Specific weaknesses we identified were:

One, an overly restrictive interpretation of the criteria to meet SSA's medical listings, resulting principally from narrow assessments of individuals' daily activities;

Two, inadequate development and consideration of a person's residual functional capacity and vocational characteristics;

Three, inadequate development and use of existing medical evidence, resulting in an over-reliance and misuse of consultative examinations; and

Four, insufficient psychiatric resources in most State DDS's.

These problems are discussed in more detail in my full statement which I would like to submit for the record. A more complete description of our findings and specific case illustrations are included in my testimony before the Senate Special Committee on Aging on April 7, 1983. I would like to skip this section, rather than to take the time to read it. I would now like to talk about the medical improvement issue which we have heard some discussion about this morning.

The issue in medical improvement is whether there should be a medical improvement requirement in order to terminate beneficiaries who are already on the disability rolls.

Since 1976, SSA has been determining continuing eligibility on the basis of whether a beneficiary's present medical condition meets the standards for disability at the time of review, regardless of whether the condition has improved, or whether the relevant criteria or its interpretation has changed since the beneficiary was awarded benefits. This policy also applied before 1969. Between 1969 and 1976, however, beneficiaries were generally not subject to benefit terminations if their medical conditions had not improved, unless the original awards were clearly erroneous.

In response to a March 7, 1983, request from Senators Levin and Cohen of the Subcommittee on Oversight of Government Management, Senate Committee on Governmental Affairs, we began developing information relevant to the issue of having a medical improvement standard for CDI's. In particular, we looked at the situation that existed when SSA had a medical improvement standard—the LaBonte principle—during 1969 to 1976, and the results of a 1981 SSA study designed to identify characteristics of beneficiaries most likely to be terminated in the mandated CDI reviews. An assessment of medical improvement was part of this 21,500 SSA case study. Although we have not completed our work, we have discussed our work to date with the Senators' staff and they are aware that we are sharing our preliminary data today.

From 1969 to 1976, SSA operated under the principle that termination from the disability rolls had to be based on evidence that demonstrated medical improvement; whereas, before 1969 and since 1976, CDI cases had been treated as if they were initial applications, and medical improvement did not need to be shown.

Frances LaBonte was a claimant who had been initially denied disability, but was subsequently awarded after an appeal and a hearing by a hearing examiner—currently called ALJ's. Subsequent to the award, a CDI was conducted. Because there was no change in the beneficiary's condition at the time of the medical reexamination, the benefits were continued. However, the State agency involved in the decision questioned the hearing examiner's award, and requested guidance from SSA.

In a March 13, 1969, memorandum to the State agency, the Assistant Director of SSA's Bureau of Disability Insurance said:

> If, at the time of the initial decision, the inferences from the evidence reasonably supported a favorable decision, substantially similar evidence in a later continuing disability investigation should not be used to find current cessation based solely on different inferences. Unless current evidence at the time of the continuing disability investigation shows a material change in the claimant's situation, the period of disability established by the hearing examiner should administratively be held to be continuing. Material change in this context involves either medical improvement to a point consistent with substantial gainful work, or an actual return to substantial gainful activity.

In 1969, the LaBonte principle—named after the beneficiary—was informally adopted by SSA to avoid using the CDI process as a mechanism for overturning Bureau of Hearings and Appeals determinations with which claims examiners may disagree. The policy was formally incorporated in the operating manuals in December 1971, and provided that if the CDI reviewer determines a disability does not presently exist and medical improvement had not occurred since the previous determination, benefits were to continue or the case should be reopened under the rules of administrative finality. In cases where the question of improvement could not be resolved, the disability determination was to be made on the basis of a current assessment of the beneficiary's condition. Also, where the claimant's medical condition was unchanged, but his vocational competence improved significantly, a new evaluation in terms of his present work capacity was required.

It is difficult to determine what the effect of the LaBonte principle was on the CDI termination rates during its use because no statistics were developed as to what proportion of the continuances were due to the LaBonte principle versus regular findings of continuing disability. The overall termination rate for medical CDI's did sharply increase, however, after SSA discontinued using the LaBonte principle. In the year following its discontinuance, 1977, the termination rate was 39 percent; whereas, the highest termination rate during the previous 4 years was 24 percent. In 1979, the termination rate reached a high of 48 percent.

The medical improvement requirement was dropped administratively in June 1976. SSA believed this would remedy the difficult decision of judging whether medical improvement occurred, assure equal treatment of all beneficiaries, reduce program and administrative costs, and remedy poor initial awards, including some ALJ decisions.

In addition, we looked at the social security redesign study. To assess the potential significance of a medical improvement standard, we drew upon the results of an SSA study done during 1980-81 which included information on how many beneficiaries on the rolls had medically improved. A purpose of the study—the redesign study—was, in preparation for the congressionally mandated CDI reviews, to develop profiles of cases most likely to be ceased or continued and of disabilities that could be classified as permanent.

One of the characteristics developed was whether there was medical improvement between the initial award and the CDI. The study consisted of a sample of 21,521 beneficiaries awarded benefits between 1970 and 1978 who were still receiving benefits in January 1980—projectable to about 60 percent of everyone on the rolls at that time. CDI's were done on each of these sampled cases during the study, and 6,923, or 32 percent were found to be ineligible and terminated. One-third, 33 percent, of those terminations were determined to be beneficiaries who had not medically improved; 54 percent had medically improved; and in 13 percent, medical improvement was undeterminable.

We further analyzed SSA's redesign cases to develop additional information on the reasons for the terminations where there was no medical improvement. We also developed information regarding beneficiaries who appealed their terminations to the ALJ level by matching automated files of all 6,923 terminated cases with SSA's Office of Hearings and Appeals files and with the SSA master beneficiary records.

We believe the results of the redesign study are significant to the issue of the lack of a medical improvement standard for the CDI reviews. We found that the primary contributing factors to the terminations of those without medical improvement were changes in adjudicative criteria and climate around 1979 including: one, the introduction of the vocational grid; two, changes in certain criteria in the medical listings; three, additional criteria for evaluating whether impairments were severe, and four, a tightening of the use of "equaling the listings" as a basis for award or continuance. These changes appeared to account for nearly all the terminations without medical improvement.

Beneficiaries who had been placed on the rolls by an appellate level were proportionately the hardest hit. Although initial disability awards by ALJ's and the U.S. courts accounted for only 12 percent of the 21,521 sampled redesign cases, they accounted for 20 percent of the terminations. Of the 2,303 termination cases where the beneficiaries' condition had not improved, initial awards by ALJ's and U.S. courts accounted for 31 percent.

Our analysis of the redesign study results indicated that about 47 percent of all redesign CDI terminations were back on the disability rolls by April 1983. Most of these were put back on by ALJ's. ALJ's made decisions on 49 percent of the terminations and 71 percent of these decisions were reversals.

I would like to make some comments now that are not in my statement dealing with the issue of a moratorium. It is an issue that has been talked about today. I would like to share our views on it.

Basically, I think some things need to be taken into consideration when we talk about moratoriums. Some of the things have already been alluded to. I think it is a good device, it is a tool to buy some time to install whatever changes are necessary. I think it also forces us, the administration, the Congress, to focus on what really needs to be done and the timeframe within which we need to get those things done. So to that extent, I think the real issue, the issue that we are trying to get at in these hearings, is what really needs to be done to bring about the changes to make the program more reasonable and accurate in the decisions.

We found as a result of our work in the area, that SSA has already initiated many of the changes which we feel could bring about a good bit of the balance that has been missing. Most of the causes that we identified, and I didn't read, but are summarized in my statement today, can be corrected and should be corrected administratively. I think it could be done quickly and administratively by SSA.

Basically I am talking about the climate—social security can change the climate very easily by changing the signals that are going down to the DDS's.

By changing the way it is looking at cases where the DDS has decided to continue a case and the disability adjudicative branch looks at it and says, "No, this person should be off the rolls."

Another quick change can occur in the way the consultive examinations are done, and when they are done, and how they are used.

Some of the things we identified in terms of improvements needed cannot be done so quickly. And this is where the moratorium question becomes more relevant. I am talking specifically about the psychiatric resources which are not in the system now, and which are needed to do these delicate examinations and make these important decisions.

I think the question of the medical improvement which we are talking about here, and which I spent the most time on, will take a little bit more time to study, to look at the pros and cons of it. And I think, of course, the overall question of standards and looking at the medical criteria will take sometime.

I think there are some options, though, and I think one option that I would like to propose for consideration is one which might be to continue the CDI processes, but only terminate those cases where there is a specific good reason, such as that a person has already returned to work, or shown evidence that he is capable of going back to work. Also where there is clearly an erroneous initial decision made, or where fraud is evident. Or as we have found in some of our other reviews, the person has died and the checks continue to be paid. Or where there is clear medical improvement.

And again I will get back to the medical improvement issue, because the thing that we started with, when we issued our report in March 1981 was heavily involved in the question of medical improvement. Social security was supposed to be scheduling people when they awarded benefits for reexamination. It was supposed to be telling people that "Your impairment has some potential of improving, you have some potential of going back to work and we are going to schedule you for reexamination in 6 months, 12 months, 18 months." Social security wasn't doing that.

A lot of reexams that were scheduled were never done. Others were not scheduled that should have been done.

At any rate, social security at that time and still today uses that diary system, and it is based on anticipation of some medical improvement. So I think the medical improvement standard is already implicit to some extent in the program.

I would also like to comment on one additional item. I am not sure whether it was the same item that Mr. Cohen was dealing with.

He was dealing with the 15-35-65 percent, and I don't know whether he meant preeffectuation reviews or the periodic review. This wasn't quite clear, because he was talking about the need to do total reexaminations. That is periodic to me, rather than preeffectuation. It wasn't clear. But my point is from our experience, once this initial reexamination of those people who legitimately should be back to work or should not be on the rolls is done, I am not sure that the law should stay in effect. I think it should be considered whether Social Security should continue to do this year after year after year. And the reason I say that is that I think there is a lot more emphasis going into the initial decisions now, with the preeffectuation review, and trying to make those initial decisions accurate and correct.

I think if Social Security went back to the system they were supposed to be using, and identified people right up front who they expect to medically improve, tell them they are going to be scheduled and that they are not retiring on disability, and then do those scheduled reexaminations, the system in fact should work appropriately, without the need and the additional burden of going through the files every 3 years.

That concludes my statement, Mr. Shannon. I would be happy to respond to your questions.

[The prepared statement follows:]

STATEMENT OF PETER J. MCGOUGH, DIRECTOR, OFFICE OF PROGRAM PLANNING, U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and Member of the Subcommittee, we are pleased to be here today to discuss the Social Security Administration's (SSA's) efforts over the last two years in reexamining the continued eligibility of persons on the disability rolls. These reexaminations, mandated by the Social Security Disability Amendments of 1980 (Public Law 96-265), are referred to as Continuing Disability Investigations or CDIs.

Since March 1981, SSA has conducted CDIs on over 900,000 beneficiaries, and almost 400,000 have been terminated. The current termination rate at the initial decision level is 44 percent.

These reviews have been the subject of significant publicity and nationwide attention. Congressional concern has been intense through hearings, legislation, and other oversight activities. We have responded to many Congressional requests regarding these reviews over the last 18 months and have testified at several hearings.

SSA has taken several initiatives over the last year to improve the review process, and recently, the Secretary of HHS announced a major reform package to further improve the process for the mentally impaired as well as the physically impaired.

My testimony today will focus on two issues—the problems with adjudicating persons with mental impairments, and the issue of a possible medical improvements standard for all CDIs.

BACKGROUND—EVOLUTION OF EVENTS

In March 1981,[1] GAO reported to the Congress that SSA had not adequately followed up to verify that disability insurance beneficiaries remained disabled. The primary emphasis of this report was on problems with SSA's medical reexamination diary process, which at that time was SSA's only means of following up on beneficiaries on the rolls. We said that SSA was not establishing a reexamination diary on all beneficiaries who were expected to medically recover, and was not reexamining all beneficiaries who were diaried for a follow-up investigation. The report said that, based on a nationwide sample case review conducted in 1979 by SSA, as many as 20 percent of the persons on the disability rolls were not disabled. SSA conducted a follow-up study in 1980 and 1981 and found that 26 percent of the beneficiaries on the rolls during July/September 1980 were not disabled.

Congressional concern over SSA's medical reexaminations and other inadequate review procedures led to the enactment of Section 311 of the Social Security Disability Amendments of 1980. This section required that beginning January 1, 1982, SSA review, at least once every 3 years, the status of disabled beneficiaries whose disabilities have not been determined to be permanent. SSA began the reviews in April 1981.

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[1] More Diligent Followup Needed to Weed Out Ineligible SSA Disability Beneficiaries, HRD-81-48, March 3, 1981.

Since our March 1981 report, studies have focused on SSA's disability reexamination efforts and the high termination rate, which was in excess of 40 percent through 1981 and 1982. Part of this high termination rate included people who had recovered and others who perhaps should never have received disability benefits. We pointed out in previous testimony, however, that many individuals losing their benefits had been on the rolls several years, still had severe impairments, and had experienced little or no medical improvement. We concluded that many of the terminations were caused because of a changed adjudicative process and climate, and weaknesses in State agency medical development practices. These conclusions were especially applicable to SSA's mentally disabled and I would like to briefly summarize the results of our review of the process for adjudicating mental impairments.

PROBLEMS WITH ADJUDICATING MENTAL IMPAIRMENTS

Our review revealed several weaknesses in SSA's and the States' Disability Determination Services (DDSs) adjudicative policies and practices. Specific weaknesses we identified were:

(1) An overly restrictive interpretation of the criteria to meet SSA's medical listings, resulting principally from narrow assessments of individuals' daily activities;

(2) Inadequate development and consideration of a person's residual functional capacity and vocational characteristics;

(3) Inadequate development and use of existing medical evidence, resulting in an over-reliance and misuse of consultative examinations; and

(4) Insufficient psychiatric resources in most State DDSs.

These problems are discussed in more detail below. A more complete description of our findings and specific case illustrations are included in my testimony before the Senate Special Committee on Aging on April 7, 1983.

OVERLY RESTRICTIVE INTERPRETATION OF SSA'S MEDICAL CRITERIA

SSA's regulations contain a set of medical evaluation criteria—referred to as the medical listings—describing impairments that are presumed to be severe enough to prevent an individual from working. If a person meets the criteria, he or she is awarded disability.

Mental impairments in the listings are categorized as: (1) chronic brain syndromes, (2) functional psychotic disorders, (3) functional nonpsychotic disorders, and (4) mental retardation. With the exception of mental retardation, the listings for mental impairments include an "A" part and a "B" part. For example, the listings for a schizophrenic (functional psychotic) disorder include part A—"manifested persistence of one or more of the following clinical signs: depression (or elation), agitation, psychomotor disturbances, hallucinations, or delusions . . .", and part B—"resulting persistence of marked restriction of daily activities and constriction of interest and seriously impaired ability to relate to other people". To be eligible for disability benefits, both part "A" and all of part "B" must be met.

Although the criteria for meeting the medical listings for mental impairments have not changed substantially since 1968,[2] it has become increasingly difficult for mentally-impaired individuals to meet the medical listings. As a result of our case review and discussions with examiners in 5 DDSs, the problem focuses principally on part B of the listings. Examiners were concluding that individuals did not meet part B based on very brief descriptions of the individuals' performing only rudimentary daily activities—such as watching television, visiting relatives, fixing basic meals, and doing basic shopping activities. Often little else positive was contained in the medical evidence.

HARD LINE TAKEN BY SSA

We asked examiners why they were accepting a few positive signs as support that the individuals did not have a "marked restriction of daily activities and constriction of interests and seriously impaired ability to relate to other people" (as part B requires).

The examiners we interviewed told us it is difficult for them to determine when restriction of daily activities, constriction of interests, and inability to relate to other poeple are severe enough to meet the lisings. The examiners also said SSA is taking a hard line in interpreting the criteria.

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[2] The I.Q levels for mental retardation were changed in 1979 to "59 or less," instead of "49 or less".

How the criteria are applied by SSA is of fundamental importance because cases are evaluated by SSA's quality assurance system, and State agencies look to case returns from SSA's Regional Office Disability Assessment Branches (DABs) as the clearest indicator of SSA's intent. State officials and examiners we spoke with unanimously preceive DAB returns over the past several years as intending to make it extremely difficult to meet the listings, and they have responded accordingly in their decisions. Several examiners told us that it only takes a few returns before you change the way you evaluate evidence.

We reviewed some of these case returns where the DDS had determined the individuals were very severely mentally impaired and were disabled, but the DAB returned the cases because the individuals had some daily activities, albeit extremely minimal ones. Our findings generally confirmed what the examiners had told us.

The following comment in a December 1981 letter to SSA's Chicago Regional Office from the DDS Director in Wisconsin addresses the impact of the DAB reviews in setting the adjudicative climate:

"The current adjudicative climate involving mental impairments seems to be one of deny, deny, deny. The rationales for these denials as promulgeted by DAB reviewers, seems to be based on the most minimal possible understanding of mental impairments in terms of their effect on individuals, on the fluctuations involved in the behavior of those with such impairments, and in trying to relate minimal ability to function in activities literally necessary to continued life, with the capability of going out in the competitive world and obtaining and holding a job with the normal stresses, under supervision and with the necessity to be able to perform consistently."

We spoke to SSA's chief psychiatrist and two other SSA psychiatrists about our findings and about difficulties in making medical assessments of an individual's daily activities (part B). They said to make a severity determination of a person's daily activities it is necessary to evaluate comprehensively the quality of the activity, how often it is done, whether independently or under supervision, with what degree of comprehension, and how appropriate the activity is. Other contributions should include whether the claimant is living independently or in a supervised/structured environment; or is on medication and the effects of it; and whether the claimant is in remission and the time spans between relapses.

CONCERNS RAISED ABOUT THE RESTRICTIVENESS OF THE LISTINGS' CRITERIA

The American Psychiatric Association and others have commented to SSA, and have testified at Congressional hearings, that the criteria in the listings are overly restrictive, and have recommended changes in parts A and B of the listings. In 1982, the Chicago Regional Medical Advisor for SSA wrote that it is: "practically impossible to meet the Listings . . . for any individual whose thought processes are not completely disorganized, is not blatantly pshychotic, or is not having a psychiatric emergency requiring immediate hospitalization . . . In fact an individual may be commitable due to mental illness according to the State's Mental Health Codes and yet found capable of 'unskilled work' utilizing our disability standards . . ."

Virtually every examiner that we talked with echoed these observations. We were told that to meet the listings an individual had to be actively and continually manifesting clinical signs. Even claimants severely impaired, and currently or recently hospitalized, were found not disabled. Our group discussions with examiners produced comments to the effect that unless a claimant was "flat on his back in an institution," "comatose," or "in a catatonic state," he or she would not meet the listings.

RESIDUAL FUNCTIONAL CAPACITY AND VOCATIONAL CHARACTERISTICS ARE NOT APPROPRIATELY CONSIDERED

When an individual fails to meet the listings but the impairment still limits his or her ability to perform basic work functions, SSA's process to determine disability requires that an assessment be made of the individual's residual functional capacity (RFC). In mental impairments an RFC should consider such factors as, "capacity to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers, and customary work pressures in a routine work setting." If the RFC assessment finds the individual incapable of doing his or her previous work, an assessment must then be made of the individual's RFC and such vocational characteristics as age, education, and work skills to see if he or she can do other work in the national economy.

As difficult as it is to meet the criteria in the medical listings, the chances of a younger individual getting or sustaining benefits based on RFC and vocational factors is extremely slim. As we found in many of the cases we reviewed, when an individual does not meet the listings, SSA's guidance to the States resulted in a virtual presumption that he or she has the RFC to do basic work activities or unskilled work. We found little indication that thorough vocational assessments were being done.

We traced the evolution of this policy guidance back to April 1979 with SSA's publication of Informational Digest 79-32. The digest stated in part that "the capacity for unskilled work . . . in and of itself represents substantial work capability and would generally be sufficient to project a favorable vocational adjustment for claimants with solely mental impairments."

Several examiners told us that DAB and other quality assurance returns have given them a clear message to terminate benefits for younger workers who do not meet the medical listings.

In May 1982 the Mental Health Association of Minnesota filed a class action suit against SSA's policies regarding mental impairments in the Fourth Division Minnesota District Court. The court concluded that,

". . . A new policy was developed by SSA beginning in early 1980 concerning eligibility for mentally impaired claimants. In accordance with that policy, SSA determined that persons whose mental impairments does not meet or equal the Listing of Impairments retain sufficient residual functional capacity to do at least unskilled work."

The court ruled in favor of the Association and said, in part, of SSA's policy that:

"The policy . . . is arbitrary, capricious, irrational, and an abuse of discretion.

"By use of this policy, the defendant has terminated the benefits of and denied new benefits to class members without proper assessment of the individuals' capacity to engage in substantial gainful activity."

As required by the court, the Commissioner, SSA, sent a memorandum to all Regional Commissioners on January 3, 1983, stating in effect that to presume a person who does not meet or equal the listings maintains the RFC to perform unskilled work is contrary to federal regulations. In addition, in March, and again in April 1983, SSA issued instructions to the DDSs dealing with mental impairments and their effects on individual work abilities. The instructions provide greater flexibility for determining the ability of a mentally disabled person to do work and may result in more accurate disability decisions. They do not change existing procedures, but are intended to make sure the adjudicators clearly understand the existing procedures for evaluating the RFC assessments and considering the vocational factors in cases of mental impairments.

INADEQUATE DEVELOPMENT AND USE OF EXISTING MEDICAL EVIDENCE

The Social Security Act requires that mental impairments causing disability be demonstrated by medically acceptable clinical techniques. When possible, all medical evidence should be obtained from existing sources, including physicians and institutions.

In many of the cases we reviewed, the existing medical evidence of record, including evidence already in the case file, had not, in our judgment, been appropriately considered. Rather, undue reliance was often given to purchased consultative examination (CE) reports, using them as the primary evidence on which decisions were based.

Examiners we spoke with at the five DDSs visited confirmed this. In our group discussions with examiners, they told us they order CEs automatically when they receive the case folders. They pointed out that it is almost a waste of time developing thorough longitudinal histories on a person who has some positive characteristics, which they interpet as not meeting the listings. They pointed out to us that if a medical/vocational allowance is warranted they would have to develop the claimant's negative characteristics fully, which is timeconsuming, and in the end they feel the case would probably be returned from the DAB because the person would be viewed as being able to do unskilled work. The examiners say they are then penalized on two counts—their backlogs increase and an error is charged against them.

Examiners also said that, because of production and processing time goals to adjudicate cases, they are reluctant to wait for or obtain all the historical data. They said it is much easier and faster to develop and justify a medical/vocational termination with a positive CE report.

The problem with over-relying on a CE report is that the CE physician rarely has the complete medical history to assess the patient, which can result in the physician relying on the individual's condition at that particular point in time and on the individual's description of his or her history and daily activities. The illness itself may prevent the claimant from accurately portraying such information. Also, if claimants want to appear normal, they may exaggerate their conditions or activities.

Examiners told us that SSA's policy of focusing on daily activities often leads to an over-reliance on CE examinations, which always describe claimants' daily activities. As we said earlier, because of SSA's restrictive interpretations of the medical listings, any positive daily activities that the claimant does are likely to result in a disability denial.

CE reports usually describe the daily activities as he or she "watches television," "visits relatives," "shops," "cooks own meals," etc. Examiners, however, cannot assess the quality of a person's daily functioning and behavior from a simple description of activities.

In a discussion with the SSA psychiatrists, they confirmed that it is unlikely that a thorough psychiatric evaluation can be prformed on an individual in a CE session without the individual's medical history, prior work history, workshop evaluations, and history of daily activities. These necessary elements are often lacking in CE reports, and are not being developed by the State examiners.

STATE PSYCHIATRIC RESOURCES ARE SEVERELY LIMITED

Overall, we found that there is a shortage of in-house psychiatric medical staff available for advice within the SSA/State adjudicative system. Nationally, as of December 1982, four States and the District of Columbia had no in-house psychiatrists, and 36 others had, by SSA standards, a deficiency in the minimum psychiatric-hours required. SSA and State officials said the limited fee rates established by the States are significantly less than a competitive rate and thus, they cannot hire or contract with more psychiatrists.

In the five DDSs visited, three did not have any psychiatrists reviewing cases and two were significantly understaffed relative to SSA's psychiatric requirements. Because the process encompasses a medical (psychiatric) evaluation that is highly complex, we asked SSA's psychiatrists whether a lay person or a non-psychiatric physician has the expertise to make such an assessment. They said examiners would not be technically qualified nor would most physicians of other medical specialties.

MEDICAL IMPROVEMENT REMAINS A MAJOR ISSUE

The second issue I want to discuss is an important policy question confronting SSA and the Congress. The issue is whether there should be a medical improvement requirement in order to terminate beneficiaries who are already on the disability rolls.

Since 1976 SSA has been determining continuing eligibility on the basis of whether a beneficiary's present medical condition meets the standards for disability at the time of review, regardless of whether the condition has improved, or whether the relevant criteria or its interpretation has changed since the beneficiary was awarded benefits. This policy also applied before 1969. Between 1969 and 1976, however, beneficiaries were generally not subject to benefit terminations if their medical conditions had not improved, unless the original awards were clearly erroneous.

In response to a March 7, 1983, request from Senators Levin and Cohen, of the Subcommittee on Oversight of Government Management, Senate Committee on Governmental Affairs, we began developing information relevant to the issue of having a medical improvement standard for CDIs. In particular, we looked at the situation that existed when SSA had a medical improvement standard (the "LaBonte principle") during 1969 to 1976, and the results of a 1981 SSA study designed to identify characteristics of beneficiaries most likely to be terminated in the mandated CDI reviews. An assessment of medical improvement was part of this 21,500 SSA case study. Although we have not completed our work, we have discussed our work to date with the Senators' staff and they are aware that we are sharing our preliminary data today.

LA BONTE PRINCIPLE

From 1969 to 1976, SSA operated under the principle that termination from the disability rolls had to be based on evidence that demonstrated medical improvement; whereas before 1969 and since 1976, CDI cases had been treated as if they were initial applications, and medical improvement did not need to be shown.

Frances La Bonte was a claimant who had been initially denied disability, but was subsequently awarded after an appeal and a hearing by a hearing examiner (currently called ALJs). Subsequent to the award, a CDI was conducted. Because there was no change in the beneficiary's condition at the time of the medical reexamination, the benefits were continued. However, the State agency involved in the decision questioned the hearing examiner's award, and requested guidance from SSA.

In a March 13, 1969, memorandum to the State agency, the Assistant Director of SSA's Bureau of Disability Insurance said

"... If, at the time of the initial decision, the inferences from the evidence reasonably supported a favorable decision, substantially similar evidence in a later continuing disability investigation should not be used to find current cessation based solely on different inferences. Unless current evidence at the time of the continuing disability investigation shows a material change in the claimant's situation, the period of disability established by the hearing examiner should administratively to be held to be continuing. Material change in this context involves either medical improvement to a point consistent with substantial gainful work, or an actual return to substantial gainful activity."

In 1969, the La Bonte principle (named after the beneficiary) was informally adopted by SSA to avoid using the CDI process as a mechanism for overturning Bureau of Hearings and Appeals determinations with which claims examiners may disagree. The policy was formally incorporated in the operating manuals in December 1971, and provided that if the CDI reviewer determines a disability does not presently exist and medical improvement had not occurred since the previous determination, benefits were to continue or the case should be reopened under the rules of administrative finality.[3] In cases where the question of improvement could not be resolved, the disability determination was to be made on the basis of a current assessment of the beneficiary's condition. Also, where the claimant's medical condition was unchanged, but his vocational competence improved significantly, a new evaluation in terms of his present work capacity was required.

It is difficult to determine what the effect of the La Bonte principle was on the CDI termination rates during its use because no statistics were developed as to what proportion of the continuances were due to the La Bonte principle versus regular findings of continuing disability. The overall termination rate for medical CDIs did sharply increase, however, after SSA discontinued using the La Bonte principle. In the year following its discontinuance (1977) the termination rate was 39 percent; whereas, the highest termination rate during the previous four years was 24 percent. In 1979 the termination rate reached a high of 48 percent.

The medical improvement requirement was dropped administratively in June 1976. SSA believed this would remedy the difficult decision of judging whether medical improvement occurred, assure equal treatment of all beneficiaries, reduce program and administrative costs, and remedy poor initial awards—including some ALJ decisions.

REDESIGN STUDY RESULTS

To assess the potential significance of a medical improvement standard, we drew upon the results of a SSA study done during 1980–1981 which included information on how many beneficiaries on the rolls had medically improved. A purpose of the study (the "Redesign" study) was, in preparation for the congressionally mandated CDI reviews, to develop profiles of cases most likely to be ceased or continued and of disabilities that could be classified as permanent.

One of the characteristics developed was whether there was medical improvement between the initial award and the CDI. The study consisted of a sample of 21,521 beneficiaries awarded benefits between 1970 and 1978 who were still receiving benefits in January 1980 (projectable to about 60 percent of everyone on the rolls at that time). CDIs were done on each of these sampled cases during the study, and 6,923, or 32 percent were found to be ineligible and terminated. One-third (33 percent) of these terminations were determined to be beneficiaries who had not medically improved, 54 percent had medically improved, and in 13 percent medical improvement was undeterminable.

We further analyzed SSA's redesign cases to develop additional information on the reasons for the terminations were there was no medical improvement. We also developed information regarding beneficiaries who appealed their terminations to the ALJ level by matching automated files of all 6,923 terminated cases with SSA's Office of Hearings and Appeals files and with the SSA Master Beneficiary Records.

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[3] Under the rules of administrative finality, a disability determination may be reopened and revised—within 1 year for any reason,—within 4 years for good cause, which is defined as a clerical error, an error on the face of the evidence (regardless of whether the determination was favorable to the claimant), and new material evidence, or—at any time where the determination was procured by fraud or similar fault and for an error on the face of the evidence if the determination was unfavorable to the claimant.

We believe the results of the redesign study are significant to the issue of the lack of a medical improvement standard for the CDI reviews. We found that the Primary contributing factors to the terminations of those without medical improvement were changes in adjudicative criteria and climate around 1979 including (1) the introduction of the vocational grid, (2) changes in certain criteria in the medical listings, (3) additional criteria for evaluating whether impairments were severe, and (4) a tightening of the use of "equalling the listings" as a basis for award or continuance.[4] These changes appeared to account for nearly all the terminations without medical improvement.

Beneficiaries who had been placed on the rolls by an appellate level were proportionately the hardest hit. Although initial disability awards by ALJs and the U.S. Courts accounted for only 12 percent of the 21,521 sampled redesign cases, they accounted for 20 percent of the terminations. Of the 2,303 termination cases where the beneficiaries' condition had not improved, initial awards by ALJs and U.S. Courts accounted for 31 percent.

Our analysis of the redesign study results indicated that about 47 percent of all redesign CDI terminations were back on the disability rolls by April 1983. Most of these were put back on by ALJs. ALJs made decisions on 49 percent of the terminations and 71 percent of these decisions were reversals.

SUMMARY

In summary, Mr. Chairman, we have identified weaknesses in the disability adjudication process, and our most recent work focused on the mentally ill. However, it is also important to point out that SSA has already moved forward with several actions to improve the adjudicative process generally and specifically for the mentally ill. The additional guidance sent to claims examiners points out the need for complete development of medical evidence, including more thorough assessments of daily activities. The guidance also points out the need for more thorough assessments of work capacity. These instructions, if properly reinforced and monitored through quality assurance activities, should lead to more accurate decisions. SSA has also increased its monitoring of the consultative examination process, including steps to help assure that consultative examination physicians are supplied with a complete medical history on the claimants.

The insufficiency of psychiatric resources cannot be solved quickly, however. It will likely remain a problem for some time. It is also very workload dependent. The more mental impairment cases there are to be adjudicated, the more serious the problem.

We continue to believe that the issue of a medical improvement standard should be addressed by the Congress, and if a standard is desired, the appropriate criteria should be specifically legislated.

We are continuing to study various aspects of the disability programs and will work closely with this Subcommittee as our work progresses.

Mr. Chairman, that concludes my statement. We will be happy to answer any questions you or the Subcommittee members may have.

Mr. SHANNON [presiding]. Thank you very much, Mr. McGough.

I would just like to talk a little bit about this issue of the moratorium which you brought up at the end of your testimony. What you seem to be saying is the administration has the tools necessary to make the changes that are required without a moratorium if they want to. Is that an accurate characterization of what you are saying?

Mr. MCGOUGH. I feel that based on the work we did, they have already started to make necessary changes. The question is proper implementation, which is always important. That is what we got into in our work. And I guess I really am still on the fence a little bit, too, about the moratorium, because there are some other things that are going to take some time to do.

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[4] For example, from 1970 to 1977, over 40 percent of the awards were for equalling the medical listings. Beginning in 1978 a precipitous drop in "equalling" occurred from 32 percent to the current 8 percent of all awards. Coincidently, of the 1970 to 1978 period covered by the Redesign Study, the lowest termination rate of the Redesign cases occurred for awards made in 1978.

Mr. SHANNON. The problem is, I am frankly troubled by the degree of detail, detailed legislating that I think we are going to be required to do in this area. In the best of all possible worlds, Congress would pass legislation which gives clear signals as to what we intended, and we would have some confidence that the administration was going to read those signals correctly and we wouldn't have to get overly involved in the whole question of the administration of the program; we would leave that up to the executive branch.

But it seems clear to me that the administration has taken some signals that were given to them by the Congress and deliberately misread them, and the result of that has been a lot of hardship that was not necessary. I don't want to see that happen again.

I would have no objection, if we had an administration that we could have confidence that they are going to run the program properly, of saying, "OK, we will let you run it." But they haven't indicated a willingness to run the program fairly.

Mr. McGOUGH. I can identify very closely with Mr. Cohen's comments about the need for social security to be set up independently with some continuity of leadership and some insulation from outside forces. I think that would go a long way to holding the management of social security accountable for their actions and allowing Congress to set the broad guidelines and then, through oversight, making sure——

Mr. SHANNON. Mr. Simmons, it seemed to me, was trying to dump a lot of responsibility on you.

Mr. McGOUGH. I would just respond by saying that I am not going to try and defend how social security implemented our recommendations. I will defend our recommendation in the report that was based on the fact that they were not carrying out the program effectively.

Mr. SHANNON. The report that he referred to, when was that done?

Mr. McGOUGH. We issued it in March 1981. As is our practice, we did give them a draft of that report which outlined the positions we were taking earlier than that—I think it was in December.

Mr. SHANNON. So,——

Mr. McGOUGH. So they did have access to the report.

Mr. SHANNON. What was the basis for the report? Had the research all been done?

Mr. McGOUGH. Yes. Most of the work that we had done concentrated on looking at and documenting how social security was administering its diary system. What we document in this report is that they weren't.

Mr. SHANNON. Over what period of time was that looked at; do you know?

Mr. TICE. I don't recall the exact period of time. Of course, the study that social security did, which came up with the 20-percent figure which we quoted in the report, was centered on April 1979. They chose that month to review people on the roles and that used the criteria in effect at that time. They determined that 20 percent were ineligible.

Mr. SHANNON. Because it seems to me that the sequence was, you looked at the system in April 1979——

Mr. TICE. SSA did.

Mr. SHANNON. And in 1980, we passed a bill; and then the administration came in in 1981 and said forget what the Congress did; let's look back to the study done in 1979 and draw our own conclusions as to what needs to be done, and went further than what the bill required them to do. We put in minimum requirements. They went way beyond that and used the report from the previous experiences as the justification on that.

Mr. McGOUGH. Actually, we had issued an earlier report to the Secretary in 1978 which pointed out that there was a problem in this area, and then we followed it up with more detailed work resulting in this report, concluding that more diligent followup was needed to weed out ineligible SSA beneficiaries.

Mr. SHANNON. I am told that was 10.8 percent; not 20 percent. Is that the case?

Mr. TICE. I have never heard that figure.

Mr. McGOUGH. In the context that we used it, the report, as I mentioned, focused on the need for them to do the diary system and that they weren't. We used the social security study results to demonstrate the cumulative effect of not doing the diary system the way it was intended to be done. So, in that sense, we tested the methodology that they used and satisfied ourselves, with our own statisticians that the study results were projectable to the universe.

We did not, however, validate their decisions.

Mr. SHANNON. Do you think that there is a better way of reviewing this program than reviewing all beneficiaries who aren't permanently disabled once every 3 years?

Mr. TICE. A properly run diary process. Because it seems sensible that if you look at a given case, you either have to reach a determination that the individual was permanent and you are not expecting any medical improvement to occur, or else you are expecting the individual to medically improve and you are going to set a diary date when you expect that improvement to take place. When those dates come up, you ought to do a thorough investigation.

Mr. McGOUGH. Those people will be notified when they are scheduled and will expect to be reexamined. They would also understand that their disability payments would be terminated should they medically improve and be judged capable of doing work. I think that would be the way to go.

Mr. SHANNON. The document prepared by the staff for the subcommittee noted that there was widespread evidence of terminations without good cause in only one region, in connection with mental impairments.

Have you focused on any other disabilities, and do we have any solid evidence that there are not terminations without good cause in connection with nonmental impairments? Or do we need more evidence?

Mr. McGOUGH. I think we need more evidence. In that regard, we focused on the mental cases specifically in the detailed work that we did, which is the basis for a good bit of my testimony today. We are doing some additional work which will look at other issues, including what has happened to people who have been terminated. And we hope to have some preliminary results by the end of the summer on that.

We will be looking at a lot of issues on what has happened to these people when they were terminated from the rolls.

Mr. **Shannon**. That will be useful to us.

Your testimony has been useful to us, as well. I want to thank you for it, Mr. McGough.

Can we have Commissioner Levetan and Commissioner Bartels now?

Commissioner Levetan, certainly we have distinguished members of this committee from Georgia who always share the Georgia experience with us.

I am particularly happy to have Commissioner Bartels, as well, who, in addition to being the commissioner from Massachusetts, is a constituent of mine, accompanied by Ms. Orsey, who is a former constituent of mine.

Ms. Levetan, why don't you begin.

STATEMENT OF LIANE LEVETAN, COMMISSIONER, DE KALB COUNTY, GA., ON BEHALF OF THE NATIONAL ASSOCIATION OF COUNTIES

Ms. **Levetan**. Since we are last on the agenda, my fellow people at home would probably say, "You have done it again; you are going to have the last word."

I am county commissioner of De Kalb County, Ga., a suburb of Atlanta, Ga. I am the NACo vice chair for mental health, developmental disabilities and alcoholism.

Mr. Chairman and members of the committee, I am pleased to be here today on behalf of the National Association of Counties, NACo. We really appreciate the opportunity to present testimony on the social security disability program, as county, State, and Federal government representatives, and our colleagues in the private sector, seek better ways to administer the programs that serve our disabled citizens.

County officials have a particular interest in the disability programs that the committee is addressing. Nationwide, county governments will provide over $2 billion this year in health and welfare services. Although there is no uniform pattern across the country, almost all counties fund and administer some aspect of the social safety net that supports disabled persons, such as: social and vocational rehabilitation programs; public hospitals and clinics; community mental health centers; board and care or nursing home facilities; adult protective services; and general assistance to support needy people who don't qualify for disability insurance or SSI benefits.

It is the county government, as provider of last resort, that picks up the pieces when disabled persons and others fall through the cracks of some Federal or State system. Some rather graphic examples of such systems failures are coming to our attention at the local level, especially as a result of the Federal Government's continuing disability investigation, CDI, program. The impact is seen in our hospital emergency rooms, our county clinics, our police stations, crisis intervention centers, and acute psychiatric facilities.

The results are being felt by our county welfare programs and budgets, as well as by our needy citizens.

Many counties are definitely not equipped to step in and provide for all the needs of disabled persons when Federal assistance is disrupted. For others, the burden of local assistance, which they must bear, represents a shift of Federal fiscal responsibility to county budgets, which are to the point that we just can't absorb any more.

Given the fiscal condition of counties today, this shifting of Federal costs is an intolerable burden. Fortunately, it can be relieved by an improved Federal approach to disability determination and review, which will also be more equitable for the needy recipients. And I think I want to emphasize the word "equity."

The National Association of Counties has long supported the Federal programs for disabled people under titles II and XVI of the Social Security Act, commonly known as social security disability insurance, SSDI, and supplemental security income, SSI. We support the premise that these programs should benefit those disabled people who are truly unable to maintain themselves in substantial gainful activity—whose disability precludes their being able to get a job and keep it.

In the interest of the program's integrity, it is clear that there must be periodic reviews of beneficiary claims to assure that the disability continues. Our concerns involve how the reviews get carried out, and the need for safeguards against inappropriate termination of benefits.

As reports come in from counties around the country, it is clear that the Federal effort to weed out beneficiaries who are employable has shifted considerable responsibility to county and State governments and has caused personal tragedy for individuals unable to work. The high rate of reversals on appeal attests to the inappropriate denial or loss of disability benefits and corresponding health benefits. And we have heard those statistics today. For the county governments who must step in to provide the needed assistance, it represents another intolerable fiscal burden.

Let me talk briefly about how these issues have come up in De Kalb County, Ga. In De Kalb County, there is a wide range of health and human services programs supported by the county taxpayers—over $22 million of county funds for these essential programs in 1983.

When needy disabled people are denied or lose their social security disability benefits, they turn to De Kalb County for general assistance—which is the only logical place that they should turn to, because that is closest to home, the government that is closest to the people—a program funded entirely with county tax dollars. As of December 1982, 21 percent of our general assistance recipients were new cases who had lost their Federal disability benefits but were unable to work. And I think that this is a tremendous percentage.

People were forced to move out of their homes as their benefits dropped. Some children were placed in foster care when their disabled mother was unable to find work. The disruption in people's lives contributed to expanded use of emergency services and even police assistance in some cases. So you can see the spiraling impact of these cases.

For clients in the De Kalb County mental health and retardation programs, I must admit, there has been less of a problem, but only because our county case managers have stepped in and personally guided people through the appeals process. They have insisted that people be interviewed in person and that current information from their own physician and counselors be used. Unfortunately, many disabled people do not have access to this kind of assistance in many counties throughout the United States. We, in De Kalb County, are very fortunate that we have been able to provide this kind of assistance.

In California, counties have been severely affected by the termination of benefits to over 29,000 recipients. Based on county reports, it is estimated that one-half to two-thirds of those discontinued seek county assistance.

Now, what do we recommend? The National Association of Counties has considered various approaches to insure that social security disability programs benefit those who are truly eligible, and that disabled people are not subjected to overly restrictive procedures. We strongly support efforts to make the system more equitable and consistent in ways that relate to individual medical and vocational factors.

Pending implementation of the needed legislative reforms, we also support a moratorium on disability reviews, especially for people with mental impairments. The temporary moratorium would not be a substitute, of course, for needed reforms, but, if effective immediately, would halt problems caused by the reviews until legislation such as you are considering is in effect. Hopefully, that will be shortly.

Specifically, as approved by the NACo board of directors at its meeting on March 1, 1983, we support changes in the present SSDI and SSI systems that would incorporate the following principles:

Individuals may not be terminated from disability programs unless there is clear and convincing evidence of significant improvement, employability, or total failure to cooperate in the review process without good cause; disability reviews should consider all available vocational information as well as medical information; people with mental impairments should be provided with assistance in completing the review process if necessary and should have a vocational assessment based on the realistic experience of competitive employment. We feel that this is a very, very important point.

Provisions of Public Law 97-455 relating to a reasonable pace of reviews and continuation of benefits through the hearing level, scheduled to expire in October 1983, should be made permanent; and reviews and hearings should be in buildings and at locations and conducted in a manner that makes the proceedings accessible to the client. I think that this is also something that we have sort of lost touch with.

We would also support efforts to include consultative examinations specific to the mental disability, for people so affected.

It is significant to note that while problems continue, there has been some improvement over the past few months. While not as dramatic as the improvements that have been made in some counties, other counties report that the interim reforms of Public Law

97-455 and the Social Security Administration's requirement of face-to-face contact in the continuing disability investigations program have slowed down the rate of cost shifts to counties, which we do appreciate.

However, we strongly support this Congress attention to these problems and the search for permanent reforms through needed legislative changes. The legislation needs to provide similar protections for disabled SSI applicants and recipients.

The National Association of Counties, as always, welcomes the opportunity to provide additional information and to discuss the impacts of legislative proposals. If it would be helpful to the committee, we would also be able to provide information on specific cases that illustrate the need for the kinds of reforms that we support. And I would like to say that we commend you for your willingness to expedite this matter before the August recess, and hopefully you will get the necessary support to bring about reform that is really so necessary and so important for all counties throughout this country.

Mr. SHANNON. Thank you very much, Commissioner.

[The prepared statement follows:]

STATEMENT OF LIANE LEVETAN, COMMISSIONER, DE KALB COUNTY, GEORGIA ON BEHALF OF THE NATIONAL ASSOCIATION OF COUNTIES

My name is Liane Levetan, and I am a county commissioner in De Kalb County, Georgia. I am the NACo vice chair for mental health, developmental disabilities and alcoholism.

Mr. Chairman and members of the committee, I am pleased to be here today on behalf of the national association of counties (NACo) [1]. We really appreciate the opportunity to present testimony on the social security disability program, as county, State and Federal Government representatives, and our colleagues in the private sector, seek better ways to administer the programs that serve our disabled citizens.

County officials have a particular interest in the disability programs that the committee is addressing. Nationwide, county governments will provide over $2 billion this year in health and welfare services. Although there is no uniform pattern across the country, almost all counties fund and administer some aspect of the social safety net that supports disabled persons, such as:

Social and vocational rehabilitation programs;
Public hospitals and clinics;
Community mental health centers;
Board and care or nursing home facilities;
Adult protective services; and
General assistance to support needy people who don't qualify for disability insurance or SSI benefits.

It is the county government, as provider of last resort, that picks up the pieces when disabled persons (and others) fall through the cracks of some Federal or State system. Some rather graphic examples of such systems failures are coming to our attention at the local level, especially as a result of the Federal Government's continuing disability investigation (CDI) program. The impact is seen in our hospital emergency rooms, our county clinics, our police stations, crisis intervention centers, and acute psychiatric facilities. The results are being felt by our county welfare programs and budgets, as well as by our needy citizens.

Many counties are definitely not equipped to step in and provide for all the needs of disabled persons when Federal assistance is disrupted. For others, the burden of local assistance which they must bear represents a shift of Federal fiscal responsibility to county budgets.[1] Given the fiscal condition of counties today, this shifting of Federal costs is an intolerable burden. Fortunately, it can be relieved by an improved Federal approach to disability determination and review, which will also be more equitable for the needy recipients.

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[1] NACo is the only national organization representing county government in America. Its membership includes urban, suburban and rural counties joined together for the common purpose of strengthening county government to meet the needs of all Americans. By virtue of a county's membership, all its elected and appointed officials become participants in an organization dedicated to the following goals: improving county government; serving as the national spokesman for county government; acting as a liaison between the nation's counties and other levels of government; and achieving the public understanding of the role of counties in the Federal system.

The national association of counties has long supported the Federal programs for disabled people under titles II and XVI of the Social Security Act, commonly known as Social Security Disability Insurance (SSDI) and supplemental security income (SSI). We support the premise that these programs should benefit those disabled people who are truly unable to maintain themselves in substantial gainful activity—whose disability precludes their being able to get a job and keep it. In the interest of the program's integrity, it is clear that there must be periodic reviews of beneficiary claims to assure that the disability continues. Our concerns involve how the reviews get carried out, and the need for safeguards against inappropriate termination of benefits.

As reports come in from counties around the country, it is clear that the Federal effort to weed out beneficiaries who are employable has shifted considerable responsibility to county and State governments and has caused personal tragedy for individuals unable to work. The high rate of reversals on appeal attests to the inappropriate denial or loss of disability benefits and corresponding health benefits.[3] For the county governments who must step in to provide the needed assistance, it represents another intolerable fiscal burden.

IMPACT AT THE COUNTY LEVEL

Let me talk briefly about how these issues have come up in De Kalb County, Georgia. In De Kalb County there is a wide range of health and human services programs supported by the county taxpayers—over $22 million of county funds for these essential programs in 1983.

When needy disabled people are denied or lose their social security disability benefits, they turn to De Kalb County for general assistance—a program funded entirely with county tax dollars. As of December 1982, 21 percent of our general assistance recipients were new cases who had lost their Federal disability benefits but were unable to work. People were forced to move out of their homes as their benefits dropped. Some children were placed in foster care when their disabled mother was unable to find work. The disruption in people's lives contributed to expanded use of emergency services and even police assistance in some cases.

For clients in the De Kalb County mental health and retardation programs, there has been less of a problem—but only because our county case managers have stepped in and personally guided people through the appeals process. They have insisted that people be interviewed in person and that current information from their own physician and counselors be used.

In California, counties have been severely affected by the termination of benefits to over 29,000 recipients. Based on county reports, it is estimated that one-half to two-thirds of those discontinued seek county assistance.

Sacramento County, California, addressed these problems by setting up its own advocacy program. Since 1973, the county has assisted disabled general assistance recipients to follow through on their SSDI and SSI applications, especially if the person is mentally disabled and has problems understanding the procedural requirements. As the speeded up reviews and tightened eligibility swelled Sacramento County's general assistance applications, the county expanded its advocacy program to insure that disability examiners have access to all relevant information. The county estimates that these efforts will prevent approximately $2 million in cost shifting to county taxpayers this year alone by preserving SSDI or SSI for beneficiaries who are in fact disabled.

The picture in Ramsey County, Minnesota, is somewhat different. After having over 100 new county general assistances enrollees by fall, 1982, as a direct result of loss of SSI or SSDI benefits, the county initiated a special advocacy program similar to Sacramento County's. Cost shifts to the county of approximately $150,000 were projected. Many of the new general assistance applicants were mentally disabled; all seemed clearly unable to move into competitive employment. By the beginning of 1983, however, the situation had improved to the point that Ramsey County cancelled its plan to expand the advocacy service. At least in [Federal] region V, the combination of newly required face-to-face interviews and—one may speculate—the impact of the pending litigation affecting the mentally disabled beneficiaries, has slowed the review process and made it more responsive to individual factors affecting employability.

NACO RECOMMENDATIONS

The National Association of Counties has considered various approaches to ensure that social security disability programs benefit those who are truly eligible, and that disabled people are not subjected to overly restrictive procedures. We strongly support efforts to make the system more equitable and consistent in ways that relate to individual medical and vocational factors. Pending implementation of the needed legislative reforms, we also do support a moratorium on disability reviews, especially for people with mental impairments. The temporary moratorium would not substitute, of course, for needed reforms, but, if effective immediately, would halt problems caused by the reviews until legislation such as you are considering is in effect.

Specifically, as approved by the NACo board of directors at its meeting on March 1, 1983, we support changes in the present SSDI and SSI systems that would incorporate the following principles:

Individuals may not be terminated from disability programs unless there is clear and convincing evidence of significant improvement, employability, or total failure to cooperate in the review process without good cause;

Disability reviews should consider all available vocational information as well as medical information;

People with mental impairments should be provided with assistance in completing the review process if necessary and should have a vocational assessment based on the realistic experience of competitive employment;

Provisions of PL 97-455 relating to a reasonable pace of reviews and continuation of benefits through the hearing level, scheduled to expire in October 1983, should be made permanent; and

Reviews and hearings should be in buildings and at locations and conducted in a manner that makes the proceedings accessible to the client.

We would also support efforts to include consultative examinations specific to the mental disability, for people so affected.

It is significant to note that while problems continue, there has been some improvement over the past few months. While not as dramatic as the improvement in Ramsey that have been made in some counties, other counties report that the interim reforms of PL 97-455 and the Social Security Administration's requirement of fact-to-face contact in the continuing disability investigations program have slowed down the rate of cost shifts to counties. We strongly support this Congress's attention to these problems and the search for permanent reforms through needed legislative changes. The legislation needs to provide similar protections for disabled SSI applicants and recipients.

Mr. Chairman and members of the committee, the national association of counties welcomes the opportunity to provide additional information and to discuss the impact of legislative proposals. If it would be helpful to the committee, we would also be able to provide information on specific cases that illustrate the need for the kinds of reforms we support.

Mr. SHANNON. Commissioner Bartels.

STATEMENT OF ELMER C. BARTELS, COMMISSIONER, MASSACHUSETTS REHABILITATION COMMISSION, ALSO ON BEHALF OF THE COUNCIL OF STATE ADMINISTRATORS OF VOCATIONAL REHABILITATION

Mr. BARTELS. It is my pleasure to be here today representing the Commonwealth of Massachusetts, its Governor, Michael Dukakis, and the secretary for human services, Manuel Carbello.

In the terms of social security, I am the parent agency head in Massachusetts who is responsible for both the vocational rehabilitation program and the division of disability determination services. Back when the original social security disability statute was passed, the Congress created what might have been called a compromise that was made in heaven in the sense that the Federal Government would provide a national program of social security disability, and that the States would participate through State agencies to administer the disability determination process. Back in those days, maybe the compromise was in fact made in heaven.

Having lived through the last year and a half of administering the social security disability program and all of the problems that it has had with respect to definition and administration, I would submit that that compromise was made in hell. It has been very difficult for us to be the messengers of what might be called a bad message. We all know what happens to messengers with bad messages when the messenger brings the message to the king and the king doesn't like the message. I feel much like the messenger back in the Commonwealth of Massachusetts.

I have submitted for inclusion in the record of today's hearing my formal testimony, and I would like to ask that it be included in the record.

Mr. SHANNON. It will be.

Mr. BARTELS. I would like to focus on three areas in my oral testimony: The process of determining disability, some of the content, a little bit of the history that we have had in Massachusetts around the continuing disability investigations, and then a few recommendations.

As we know, the process, as in determining disability is very complex. There are many players in the process. There is the Social Security district office; there is the DDS. Within the DDS in each State there are examiners, there are consulting physicians who work for the DDS, there are out-of-house physicians who perform exams on behalf of the Social Security Administration and the DDS. There are SSA quality reviewers, there are administrative law judges, there is the Appeals Council and the courts. And then there are documents: The regulations, the POMS that we have heard about which define the disability as far as the examiners are concerned, and the SSA bulletins that further define what disability means. This is a very complex program that takes a lot of work and effort on the part of the people that are trying to understand it to get a fix on where it is good and where it is not so good. Part of our problem in dealing with this national program is to understand in fact where the problems are and where they are not.

The second issue in the area of process was flaw in the program when the CDI's began. Social security disability recipients, when turned down at the first level, did not have the opportunity to remain on benefit through appeal, as was the case where SSI recipients, who if they had been turned down on the first level of review, would have had the opportunity to remain on benefits. Congress fixed that in December and it was signed into law on January 12. I think that change provided a great benefit to disabled claimants and should have been there when the original law to review cases was passed.

I should note that there was a great backlog of cases that were never reviewed, although they had been diaried. I think that was mentioned by the GAO representative here this morning. If those reviews had been done in a timely way, maybe we would not have had the problems that we have had over the last year and a half.

I would also like to note that the SSA criteria for disability is extremely tight. For those people that are trying to get on disability for the first time, they run into the very tight definitions around disability. If they are turned down at the first level, they have an opportunity to appeal that ultimately to the administrative law judge level. We should note that today the ALJ level is severely backlogged and that someone who seeks an appeal today may take up to a year to have that appeal heard. I think that is a great detriment to disabled people trying to get on disability, and it is certainly problematic for people trying to retain their benefits. Although they may be on payment, they have to suffer through not knowing whether they will be on disability after they appeal at the ALJ level.

In terms of content, the medical impairment area has historically been problematic. We have learned definitely that the symptomology for people who are psychiatrically disabled cannot predict whether they can work or cannot work. I think we saw that in the law suit in Wisconsin. That decision referred to very expert testimony on the part of Bill Anthony from Boston University, who has done some very good work in the area of psychiatric disabilities.

I think we have also seen it in the area of pain where the criteria that the examiners must use requires tying the pain to a medical causation. However, the administrative law judges can be more flexible than that and can, in fact, allow people to be on disability who ought to be on disability. I think the ALJ's have brought a lot of sense to the disability program which maybe wasn't there in the earlier stages.

I have provided to the staff of this committee a package of material. One of the documents in it includes some very detailed changes that we would suggest for the POMS having to do with the definition of disability, and I would urge that those be seriously considered.

The next area is one that has been discussed this morning as medical improvement. We, in Massachusetts, sit in the First Circuit Court. We have a decision called Miranda, decided by the First Circuit Court back in 1975. That was never included into the social security criteria that our examiners could use. We began to examine that most carefully last year in the context of the CDI problems that people were having, and we were then looking toward a litigation with social security. In the meantime, the Commonwealth of Massachusetts, the legislature, the attorney general's office, and the executive branch of government have moved ahead to implement the medical improvement standard that is defined by Miranda. That is being looked at today by the Social Security Administration for a possible pilot project. We do not yet have a decision on their part as to whether our moving ahead on that will be fully approved by them or not. There was some early communication from Social Security that indicated that they felt that what we were doing was not appropriate, but we have moved ahead nonetheless, and we are very proud that we have done so. We have also provided to the staff copies of the Medical Improvement bulletin that we have sent out to our staff. That is available to committee staff.

Next, I'd like to outline briefly some of the history in Massachusetts when we became aware that the CDI's were causing such problems for disabled people. Back last summer, we established the commissioner's task force to look at the problems that people were having and came up with a number of recommendations in December of last year.

During the period of the study we began to implement those recommendations that we could. Some of those recommendations like creating a community relations position which we thought was important, we requested social security funds and authority to do that, but they turned it down. We requested that they allow us to send out updated criteria to treating physicians in the Commonwealth of Massachusetts. We thought it would be helpful to get treating physicians to provide good information to us as objective medical evidence. They turned that down. Social Security, when we are trying to improve the program turns around at least at our level and says, "You can't do this and you can't do that," and that is very frustrating on our part.

In January 1983 the legislature initiated a legislative commission to do much the same as we had done in the commissioner's task force in terms of getting on board with respect to the problems of the disability program. The special legislative commission focused in on the medical improvement issue and worked with the executive branch as I said in moving the Commonwealth ahead as a State to implement the medical improvements standard. The legislative commission worked very closely with the Rehabilitation Commission, with the Governor's office, with the Attorney General and with legal services advocates in the community as well as the advocacy world.

I think that coming together has been very helpful to us. There is a better understanding of the program and there is a good consensus on what needs to be done. A change in law that we would propose certainly is to continue social security benefits pending appeal and make that a permanent part of the act. That expires on October 1 of this year.

Second, we would propose that Social Security promulgate all their standards through the Administrative Procedures Act and provide a more open forum for people in the disability world and in the medical world to review the criteria that defines disability before it gets implemented by DDSs around the country. I think Social Security has moved too far too fast in finding criteria that are very detrimental to people.

We suggest that you require a medical improvement standard for the CDI process before terminating benefits, write that in the law and be very specific. We would suggest that face-to-face meetings at the DDS before people are ceased is very important and that has been discussed today.

We suggest that the mental impairment standards be changed to reflect people's actual ability to perform in the workplace. We would suggest that the eligibility standards for the social security disability program be consistent with other remedial programs such as the vocational rehabilitation program.

Also in being here today as a member of the Council of State Administrators of Vocational Rehabilitation, I would like to ask that the testimony of the Council be inserted in the record of this hearing and make two short comments with respect to the vocational rehabilitation program.

The Rehabilitation Services Administration has a long standing history of administering the vocational rehabilitation program to help handicapped people get to work. Prior to the changes in the

Act in 1980, the Rehabilitation Services Administration was performing that program on behalf of Social Security. I would suggest that the Rehabilitation Services Administration be authorized through law to administer that program on behalf of Social Security again. I would also like to suggest that the reimbursement program that is defined presently for the rehabiltation agencies that help people on SSI and SSDI get back to work be broadened to include the cost of evaluations for people where services may in fact be a failure but at least services have been provided.

That concludes my formal testimony on behalf of the Commonwealth and the Council of State Administrators of Vocational Rehabilitation.

[The prepared statement follows:]

STATEMENT OF ELMER C. BARTELS, COMMISSIONER, MASSACHUSETTS REHABILITATION COMMISSION

Mr. Chairman, Members of the Subcommittee on Social Security, thank you for the opportunty to appear before you today to share our Massachusetts experiences with the Social Security disability programs. Governor Dukakis would have liked to be here today to talk about the disability determination program in Massachusetts, as he did at a field hearing of the House Select Committee on Aging in Boston. Since it's the last day of our state fiscal year and our state legislature is still working the budget, I hope you'll excuse his absence. The Governor has taken a personal interest in the disability determination program because of the hardships it has caused for disabled people in the Commonwealth and the administrative hardship it has created for the states, which are mandated to conduct disability reviews. As the state administrator for the Social Security disability determination program, in Massachusetts, I am professionally and personally concerned about this program which has been the target of considerable public criticism and controversy for the past year and a half. This statement outlines the legislative measures that are necessary to reform the Social Security disability program so that it serves all disabled people fairly.

Later I will describe the steps that we have taken in Massachusetts to improve the program, but stress that it's critical for Congress to act now on comprehensive legislation to ensure fair and equitable standards for this program. Briefly we need legislation that will:

1. Permanently continue Social Security disability benefits and medicare/medicaid throughout the administrative appeal process;
2. Require publically promulgated standards and procedures for disablity that accurately measure a person's medical condition and capacity for work;
3. Require that the Social Security Administration adhere to a medical improvement standard before terminating benefits once eligibility is initially established;
4. Provide for face-to-face meetings between claimants and state disability examiners before a negative disability determination is made in order to secure and use all medical evidence and cut down on the numbers of appeals resulting from incomplete evidence;
5. Mandate eligibility standards that are consistent with other disability programs, especially vocational rehabilitation, and a state-level disability review procedure that fully supports continued Social Security benefits during the vocational rehabilitation process.

These reforms and others included in Congressman Shannon's bill HR 2987, are urgently needed. On behalf of the Governor, I want to thank you for your attention to these problems which critically affect disabled people in our Commonwealth and throughout the Country. Next I want to explain my perspective on the Social Security disability program and the reasons why I believe this list of legislative reforms is necessary.

First, I will stress that my flexibility and discretion in administering the Social Security Disability Determination program is extremely limited. Disability standards and procedures for determining eligibility are tightly controlled by federal laws, regulations and guidelines to a minute level of detail. These standards and procedures are imposed on state agencies and are rigorously monitored by Social Security officials and functionaries in the name of quality control. The results are not good.

Each year thousands of disabled Massachusetts residents fail to meet strict Social Security disability standards and are denied benefits after their cases are reviewed by our state disability determination services division. Yet many of these same people are so disabled that they cannot work and cannot effectively participate in our agency's vocational rehabilitation program. Many claimants who appeal are made eligible for disability benefits for disability benefits by Administrative Law Judges who use different procedures and evidentiary standards for evaluating disability. Others do not appeal and so, even though their disabilities might meet the different appeals standards, do not receive the disability benefits to which they are entitled.

This system is not fair to disabled people, yet the unfairness is inherent in the present Social Security System. The disabled people of Massachusetts *and* the state administrators and disability examiners who are responsible for implementing this program desperately need Congressional intervention to comprehensively redefine the Social Security System so that the program works to treat disabled people fairly.

Much public criticism of our agency focuses on the so-called "reversal rate" for disability appeals. Based on the very strict procedures and disability standards contained in Social Security directives call "POMS", which our examiners are required to use, an individual is determined not to be disabled. If that individual appeals he or she has at least a 60 percent chance of getting a favorable decision from an administrative law judge, who sees the claimant face-to-face and uses different rules for the appeal decisions. This situation creates a perception that our agency did a poor job even though we followed the Social Security rules that govern state agencies.

The importance of face-to-face encounters cannot be understated. Recently I met a man on crutches who asked me why our disability examiner had reviewed his medical records and recommended a no disability finding. I couldn't imagine why, but I agreed to check it out. None of the medical records in his file mentioned that he could only walk with crutches. One of his physicians later verified the man's need for crutches, but had not mentioned this critical fact in the medical records.

Unlike administrative law judges, our examiners do not ordinarily see claimants, so their potential for mistakes and omissions concerning key medical facts is ever present. Congress should mandate a face-to-face meeting between claimants and state disability examiners early in the disability evaluation process. To cut down on appeals from decisions based on incomplete evidence would also reduce benefit delays and frustrations for many claimants, and would improve public perception of our agency's accuracy by giving our examiners the information needed to make more complete and accurate determinations.

Another practice that creates different decisional results is the Social Security requirement that our examiners use the POMS, which are lengthy compilations of Social Security policies and directives that are frequently changed without public review or input. The administrative law judges are not bound by the POMS, but may apply statutory and judicial law and regulations in their adjudications. The standards used by the administrative law judges directly reflect Congressional mandates and judicial interpretations as well as Social Security regulations that have undergone public scrutiny and comment. Public accountability and decisional consistency would be greatly improved by legislation requiring public review and comment for *all* disability policies and procedures, including those used by state disability examiners.

A third reason for the discrepancies between administrative law judge decisions and those of state disability determination units is the Social Security practice of "non-acquiescence", or refusal to apply the statutory interpretations of Appeals Courts within a given federal circuit to disability cases adjudicated within that jurisdiction. In 1982 the Social Security Administration issued a formal non-acquiescence ruling, refusing to adhere to the medical improvement precedents established by the Ninth Circuit Court of Appeals in the *Patti* case. (*Patti* v. *Schweiker,* 669 F.2d 582 C.C.A.9, 1982.) Basically that case held that the Social Security Act eligibility standards assume that an initial disability decision is correct and unless a claimant's condition improves, he or she is still eligible for benefits. Earlier this year, a Ninth Circuit District Court ordered the Social Security Administration to follow the law, as articulated in *Patti.* Last week Secretary Heckler indicated that her department had not decided whether to comply with the Court order or to appeal it. Here in Massachusetts we have also encountered federal reluctance in implementing the improvement standard required by a First Circuit Appeals Court decision. (*Miranda* v. *Secretary of HEW,* 514 F.2d 996 C.C.A.1, 1975.) In October, 1982 we wrote the Social Security Commissioner seeking his guidance on this matter. There was no response for months. Finally in February, 1983 we received a letter stating that the case review procedures then in place met the First Circuit improvement standards. In response to directives from Governor Dukakis, our agency moved to refine the process for complying with the First Circuit standard. This action was met with strong objections from Social Security personnel. In late April Social Security officials contacted our agency to discuss implementation of a medical improvement standard on a pilot basis. Despite numerous discussions with Social Security personnel, no agreement has yet been reached on Massachusetts implementation of a medical improvement standard.

Given the recalcitrance with which the Social Security Administration has approached the medical improvement issue, we would urge Congress to amend the Social Security Act to expressly require adherence to such a standard. The language appearing in Congressman Franks' bill, HR *1524*, articulates a good workable approach to this problem. In addition, we ask Congress to clarify the powers of the Social Security Administration to interpret the law with a more appropriate recognition of proper judicial and administrative roles in this process. Congressman Shannon's legislation, which is supported by several other members of the Massachusetts delegation, addresses the non-acquiescence issue in a constructive manner and deserves your consideration.

I also want to call your attention to the needs of particular claimant populations who often cannot meet current disability standards but nevertheless cannot work to earn a living. Social Security standards and procedures for evaluating mental impairments do not adequately measure work capacity, particularly for psychiatrically disabled individuals. Restrictive disability policies also disadvantage older people who have received disability benefits and have not worked for a long time. In addition, rigid Social Security requirements for certain medical tests and clinical findings do not properly measure the work capacities of many individuals with hidden disabilities, like painful back impairments, neurological disorders, and cardiac conditions. Legislation to specify the evidentiary weight to be given to claimant's description of pain and treating physicians' opinions would address some of these problems. Congressman Frank's bill would more fairly evaluate the disability claims of older beneficiaries whose claims are reviewed after years away from the work force.

In concluding, I will mention that over the past year and a half, our agency has worked with disability advocates, with legislators and with state officials in the executive branch to identify and solve problems in the Social Security disability determination program as it operates here in Massachusetts. Last spring our agency provided training programs for advocates to give them more information about the disability determination process so that they could more effectively help their clients apply for and retain benefits. In August, 1982 I convened a Special Task Force including advocates, consumers and agency staff to review the disability program in Massachusetts and make constructive suggestions for improvements.

I have included copies of their Report for review by you and members of your subcommittee. In December last year we temporarilly suspended notification of benefit cessations while Congress completed action on the legislation temporarily extending benefits through appeal to an administrative law judge, which became PL. 97-455. I urge you to make that provision a permanent part of the Social Security Act. A Special Legislative Commission was created last December to investigate and study the disability determination process in Massachusetts. Led by Senator Backman and Representative DeNucci, that group has been very actively involved in reviewing problems and developing solutions for reforming it. Their recommendations and the Governor's directives brought about agency action to fully implement First Circuit medical improvement standards. We are continuing to work on our own internal procedures to improve the program, especially the continuing disability investigation process. Despite some negative reactions from the Social Security Administration to certain innovations, we are committed to implementing changes so that the program will give full consideration to disabled people in Massachusetts. We need *your* support to reform the Social Security Act so that the standards for disability are fair and equitable to add disabled people. We hope that you will quickly approve and enact a comprehensive legislation package containing the provisions that I have discussed here so that the Social Security disability programs can serve all disabled people in the manner that their authors originally intended.

Thank you very much for this opportunity to share our perspectives on this important topic that affects disabled people in Massachusetts.

STATEMENT OF THE COUNCIL OF STATE ADMINISTRATORS OF VOCATIONAL REHABILITATION

The Council of State Administrators of Vocational Rehabilitation (CSAVR) is an association comprised of the chief administrators of all the state agencies providing rehabilitation services to physically and mentally disabled persons in the States, the District of Columbia, and the territories. Founded in 1940 to furnish state input into the State-Federal Vocational Rehabilitation program, the Council has, since then, served as a quasi-official advisor to its federal partner, the Rehabilitation Services Administration, and has provided a forum for State Rehabilitation Directors to study, deliberate and act upon matters pertaining to the successful rehabilitation of persons with disabilities.

Through its Committee on Social Security Relationships, the Council interacts with the Social Security Administration (SSA), the Rehabilitation Services Administration (RSA), and other groups with respect to issues affecting the Disability Insurance Program (Title II of the Social Security Act), the Supplemental Security Income Program (Title XVI of the Social Security Act), and the Beneficiary and SSI Rehabilitation Programs..

Mr. Chairman, the Council is pleased to have this opportunity to present to the Subcommittee its veiws and concerns with respect to the SSDI Beneficiary Rehabilitation Program (BRP).

BACKGROUND

Prior to October 1, 1981, State Rehabilitation Agencies received monies from the SSDI Trust Funds (allocated on a quarterly basis) and from the General Revenue (appropriated by the Congress) for the provision of rehabilitation services to eligible SSDI beneficiaries and SSI recipients. In fiscal year 1981, State Rehabilitation Agencies received over $124 million to implement these programs and provided services to over 115,000 beneficiaries with mental and/or physical disabilities.

Despite the demonstrated cost-effectiveness of these programs, the law was changed—as a part of the Omnibus Reconciliation Act of 1981—to provide that State Rehabilitation Agencies would only be reimbursed by the Social Security Administration for the cost of rehabilitation services resulting in the client's participation in Substantial Gainful Activity (SGA) for nine months. While current law does not mandate that payments be made to the states in advance, the SSA, for the present time, has chosen to do so. During Fiscal Year 1982, approximately $3 million was advanced to the States, a cut in funding from fiscal year 1981 of over 97 percent.

Under present law, states may have to wait two or more years before full reimbursement funds are made available. In addition to the period of nine months of substantial gainful activity, there are also the many months, even years, which are required to successfully rehabilitate a severely disabled person.

Prior to reimbursement, the states incur, and will continue to incur, substantial expenses for services which will significantly exceed the "advance" monies provided by the SSA. Because of this, fiscal planning is being severly disrupted, since State Agency administrators are unable to ascertain when or in what amount the reimbursement will be provided for services rendered.

In addition, no claims involving the actual determination of SGA and nine continuous months of employment are known to have been made by the SSA. Therefore, State Agencies have no basis to determine the amount of reimbursement money they will receive for services provided under this Program.

The Council has serious misgivings about some of the provisions and limitations of the current BRP. Therefore, we urge the Subcommittee to consider the following technical recommendations which we strongly believe would, if enacted into law, improve the operation of these important programs.

RECOMMENDATIONS

1. Current law places the responsibiity of administering the BRP within the Social Security Administration. While we have no major complaint with the performance of the professional staff at the SSA charged with the day-to-day operation of this program, we do question the commitment towards this program of the chief decision-makers within the SSA. Therefore, we recommend that the Commissioner of the Rehabilitation Services Administration be charged with the administration of the Beneficiary Rehabilitation Program.

The BRP is a program of Vocational Rehabilitation Services, an area in which the Rehabilitation Services Administration has far more expertise than does the Social Security Administration.

The BRP represents a miniscule portion of the Social Security Administration Budget, and consequently, is given a low priority in the SSA organization. To illustrate, regulations were not finalized until February 10, 1983, sixteen months after this program went into effect.

While the Council enjoys good working relationships with the SSA regarding the implementation of the current BRP, we are convinced that the ultimate goals of this program—the provision of necessary services to eligible beneficiaries, and the saving of monies to the Trust Funds—would be further advanced if it were administered by the Rehabilitation Services Administration.

2. In order for the current program to work effectively, the Council urges the Subcommittee to replace the "reimbursement" language in current law with clear language providing that payment to the States be made in advance. Prior to fiscal year 1982, such payments were made in advance.

3. Current law limits the definition of a "reimbursable" expense to such a degree that many State Agencies, in many circumstances, are hesitant to provide services, not knowing if the SSA will reimburse that expense. A broadening of the definition of a "reimbursable expense" will eliminate these disincentives, and make the program more operable.

State Rehabilitation Agencies should be reimbursed for all monies expended on beneficiaries who are terminated from the SSDI rolls due to "medical improvement," regardless of their work status. As the goal of SSA is to reduce the number of beneficiaries, State Rehabilitation Agencies should be reimbursed for expenses provided to an SSDI beneficiary who, while receiving services under an approved rehabilitation plan, medically recovers and no longer requires SSDI benefits.

State Rehabilitation Agencies should be reimbursed for all monies expended on SSA related cases who "refuse services" or who "fail to cooperate" in the Agency's efforts to provide such services. State Agencies currently accept for services those SSDI recipients who meet eligibility requirements, and who express an interest n receiving services. In many cases, after services are planned and sometimes provided (and after many dollars are expended) a client will decide not to continue in a rehabilitation program. State Agencies should not be penalized for their efforts in providing rehabilitation services to these individuals.

State Rehabilitation Agencies should be reimbursed for all evaluation costs associated with SSDI related cases, even if that case does not result in the achievement of SGA for nine months. This system would result in a more active and comprehensive referral system, thus resulting in the provision of services to, and the potential rehabilitation of, a much greater number of SSDI beneficiaries.

4. There should also be established a separate program, which supports the provision of rehabilitation services to SSA beneficiaries whose benefits have been terminated due to medical improvement. Most of these individuals are long-term recipients of benefits who have been out of the work force for an extended period of time.

In addition, being no longer "disabled" under the Social Security Act does not mean that the former beneficiary is readily employable. It merely means that the former beneficiary's medical condition does not preclude the performance of some type of work available somewhere in the national economy. Vocational training or counselling, or additional rehabilitation services, may be needed before that individual is able to return to productive life. For many of these beneficiaries, the needed services are only available through the State Rehabilitation Agency.

For these reasons, we strongly recommend that a program for terminated beneficiaries reimburse State Agencies for the provision of any service that may be reasonable and necessary to return the former beneficiary to suitable employment.

CONCLUSION

The Council firmly believes that if the current Beneficiary Rehabilitation Program is to be successful, certain limitations in the current law must be expanded, and certain other ambiguities must be made clear.

Mandated payments to the states, to be made in advance, are vital. Without this guarantee, planning is difficult and the provision of timely and cost-effective services is jeopardized. In that the State Rehabilitation Agency can offer the SSDI beneficiary that most comprehensive and coordinated service delivery system to meet their particular needs, a stable and reliable funding source is essential.

In addition, if the BRP is to achieve the dual goals of providing necessary rehabilitation services to eligible beneficiaries, and to achieve a savings to the Trust

Fund, the providers of services must be reimbursed for the cost of all rehabilitation services provided beneficiaries that result in a direct savings to the Trust Fund, regardless of a beneficiary's ability or inability to engage in SGA for the required time period.

The Council of State Administrators appreciates this opportunity to express its views on this important Program.

Mr. SHANNON. Thank you both for your testimony.

Commissioner Levetan, I found your testimony interesting. The thing I found most interesting was the figure you gave us on the number of people, who went on the general assistance relief program who had been terminated from or knocked from the disability rolls. It was 21 percent?

Ms. LEVETAN. Twenty-one percent.

Mr. SHANNON. One of the big problems we have right now is we don't have very much data on what happens to people once they get knocked from the rolls. As the witness from the GAO testified they are now doing a study of that. In many of these cases somebody ends up paying for the continued existence of these people, in the fortunate cases I suppose, and there are others who probably get no assistance at all.

But the savings that are projected from these kinds of Federal decisions in many cases are just shifted to the States and the local governments.

Ms. LEVETAN. I would like to say something, that I sense a great deal of sensitivity that you have displayed today. I don't get to Washington very often, but it is just very heart-warming to see someone display the kind of interest and real sensitivity that you have shown.

Mr. SHANNON. I might have to come down to Georgia to run for reelection.

Ms. LEVETAN. The point is that there is a bottom line. It is a situation that the job has got to be done. We have got to be sensitive to the needs of the individuals that really need care, and we in local goverments don't want a free lunch from anybody for our constituents, but by the same token, it just does not seem fair to shift the responsibility to the local governments.

The points made by this gentleman from your State and many of the speakers today point out the fact that the way this thing has been done, paper reviews, this is just not the way that you do things. You have to treat people like human beings with the needs and recognize them.

Of course we are going to find abuses in any system. We are going to find people who are trying to get something for nothing, but by the same token, I am convinced that there are far more people that have been subjected to loss of funding that really need it and this is a tremendous concern.

We can't let this happen. I have confidence that you will see to it that something will come about that the people who really need the help will receive it.

Mr. SHANNON. We are going to do the best we can. It certainly wasn't the intent of the legislation, nor is it required by the legislation, what happened since 1981. Maybe I could ask both of you a question on exactly what happened in your States—maybe Commissioner Bartels first, and Commissioner Levetan, if you have anything to add to this—once these reviews were required. This tremendous increase in the number of reviews was required, what did that do to your workload?

One of the things that we keep on hearing about is that a lot of the problems resulted just from a tremendous dumping of responsibilities onto the agencies, the State agencies, without an adequate time to staff up and gear up. What happened? What kind of efforts were you allowed to prepare to deal with these problems that were given you? Commissioner?

Mr. BARTELS. I can give you an example for the Commonwealth of Massachusetts. We were authorized to increase our staffing by 60 examiners. And go through—it was about a 6-week formal training process—and then begin to process initial cases. But to take an examiner who has learned how to do initial cases and bring them along to the point where they can deal with the comprehensiveness required in a CDI case and to look at all the details that go along with that, I don't think that we had sufficient time.

On the other hand, I think it is also important to note the criteria that were used to determine disability were today's criteria used against people that got on disability 2, 5, 10 years ago under a different definition of disability. And that I think was another piece of the equation.

Mr. SHANNON. So you had people who had shown no improvement over that period of time who qualified then but wouldn't now and so they were knocked off the rolls?

Mr. BARTELS. That is correct, with no medical improvement standard being applied because there is not one. I think that was doing the disabled people a great disservice. It didn't have medical improvement in there. Even though in the first circuit we had a decision, it was not implemented. In the ninth circuit there was a decision, on medical improvement, yet the Social Security Administration has nonacquiesced on both decisions until Massachusetts moved ahead. It is still not clear whether social security is going to approve or disapprove it and take disciplinary action, whatever that may be.

Ms. LEVETAN. Quite frankly, we were not in any position to increase our personnel to handle this, but we were very fortunate that we have dedicated county employees. My county is approximately 500,000 population and it meant doubling efforts. The point is when a person is cut off, they lose their homes, they have to put their children in foster care. So we have a combination of agencies pitching in to get the problem solved. It is not an easy situation and I am sure that there are many counties throughout the country that were not as fortunate as we were in De Kalb to have the amount of personnel and the doubling up. But it is something that really needs to be addressed, and it is not a simple situation, because not only as you pointed out does then the load fall on another agency, but it is then sometimes a total disruption of families that causes problems not today or tomorrow, but 5 or 10 years from now.

Mr. SHANNON. So we have the problem of the administrative nightmare by the people who had to administer the program and then the people knocked off the roles had the same kinds of problems thrust upon them?

Ms. LEVETAN. Yes.

Mr. BARTELS. One other thing mentioned was mindset. The social security mindset I think needs to be opened up and improved on behalf of disabled people. Back in December, when Congress was in the process of changing the law to allow people to remain on benefit through appeal, I took the position that we would send out no more cessations until Congress passed the law to give people every benefit of the opportunity to remain on benefit through an appeal process. Within a week the Social Security Administration came in and said, if you don't get back to the business of processing cessation cases out of the agency, we are going to withhold your Federal funds. That doesn't do disabled people any favors, especially when it was an interim measure and it seemed to make some sense with regard to fairness to people.

It is that kind of mindset issue that I think has been very problematic for us as administrators who wish to do a good job, but then find our hands tied. "We are going to take your funds and we are going to take over your programs."

Mr. SHANNON. That is the problem we have. We want to give them as much flexibility as possible and we try to do that so they can meet special needs that develop and adjust to problems that we don't anticipate, but that has turned around on us.

It is the flexibility—if we give them flexibility they use it to contradict the intent of the Congress in some of these areas. So we are put in a position where we can be criticized if we are overly specific and abused if we are not. We have to find some middle ground where we can make it clear exactly what we are intending and then make sure that they follow the intent of the law.

Let me ask you a question, Commissioner. In your written testimony you noted that your examiners must use the POM's, while the administrative law judge is not bound by these POM's but may apply statutory and judicial decisions and regulations in their adjudications. Is it your view that the POM's do not reflect in some cases the law, the statutory law and the regulations?

Mr. BARTELS. I think they reflect an interpretation that turns out to be so narrow that people are in fact denied disability, whereas if they went to an ALJ who had the person sitting in front of them, the ALJ could use some good judgment and commonsense would say yes, this person is disabled and can't work.

The POM's, just as an example, is a set of books about a foot and a half thick as opposed to the listings that are regulations out of the Federal Register, and the law. The regulations and law are a very compact document which when you apply good common sense, can result in good decisions.

Ms. LEVETAN. I would like to say one thing. The counties definitely understand the need to be sure that the tax dollars are used only for those who qualify. I think now we are being penny-wise and pound foolish in the way the program is working out now, because ultimately I think that it is going to cost us far more in the future unless we get this thing straightened out as soon as possible.

Mr. SHANNON. That is becoming apparent even here.

Ms. LEVETAN. I was absolutely flabbergasted at the figures, 199,000 versus 400-something now.

Mr. SHANNON. They really went quite overboard.

Ms. **Levetan**. This has been a real education for me, too.

Mr. **Shannon**. I want to thank you both for your testimony. It was magnificent. As the Chairman has indicated, we intend to move quickly on this issue and certainly are greatly aided by what you have told us today.

Mr. **Bartels**. On behalf of your constituents back in Massachusetts, I would thank you for your support in helping resolve the problems within the social security disability program.

Mr. **Shannon**. The next panel is Dr. Meyerson, American Psychiatric Association; Karen Litz, National Mental Health Association; and Dr. Boggs.

Dr. Meyerson, welcome to you all. Would you like to begin?

STATEMENT OF ARTHUR T. MEYERSON, M.D., CHAIRMAN, COMMITTEE ON REHABILITATION AND VICE CHAIRMAN, DEPARTMENT OF PSYCHIATRY, MOUNT SINAI MEDICAL SCHOOL, AND CLINICAL DIRECTOR FOR PSYCHIATRY, MOUNT SINAI HOSPITAL, NEW YORK, N.Y., ON BEHALF OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Dr. **Meyerson**. Thank you.

I want to express my own feeling of gratitude and that of the American Psychiatric Association for the opportunity to testify.

As you can see from this panel, and from the list of organizations that have been involved, the SSDI issue is one which is heartfelt by both providers of care, physicians and others, and beneficiaries, particularly by the mentally ill.

You have heard the figures, but I would like to bring them home to you in a more personalized way, much as Senator Pepper did at the beginning of the hearings this morning.

As you know, while the mentally ill represent only 11 percent of the people on the SSDI rolls, 30 percent of the CDI terminations have been among the mentally ill.

You have heard that when that small percentage of terminated beneficiaries who have the gumption to appeal to the level of the ALJ, across the entire population, roughly 60 to 70 percent of the terminations are overturned.

Among the mentally ill, that figure is 90 percent.

We view the high rate of terminations and then reversals to reflect as an institutionalized prejudice on the part of the SSA toward the mentally ill, whether purposive or inadvertent, is essentially beside the point.

Among the mentally ill, chronically disabled who are thrown off the SSDI rolls, we have seen suicides around the country. I personally know of two in my own institution.

We have seen the kind of hardship that was just testified to in terms of impact on the family. In terms of what is often called the bottom line, the dollar, the $400 a month that a mentally disabled person may get from SSDI is small in comparison to the costs of termination. When someone is taken off the rolls, in a larger percentage of cases, he or she requires hospitalization, psychiatric hospitalization, which amounts to $400 to $600 to $800 per day in a general hospital.

If there was ever a penny-wise and pound-foolish program, it is the one that has been administered over the last year and a half by the SSA.

The American Psychiatric Association has submitted written testimony, and I would ask, as others have, that that be included in the record.

Mr. **Shannon**. All of your statements will be included fully in the record.

Dr. **Meyerson**. Thank you, sir.

I will simply read briefly some specific recommendations which I think others have elucidated quite well, and which we support.

First of all, we obviously support and endorse your own bill, H.R. 2987. We feel the legislation addresses very important issues, such as accurate assessment of a person's ability to work—upon which I will comment a bit more; whether a person's medical condition has improved on CDI; the use of appropriate personnel to make informed medical decisions regarding both the person's impairment and/or disability; the need to update and improve existing medical criteria for the assessment of disability before further reviews are conducted—that is dealing with the moratorium, which we support; and the provision of a face-to-face meeting at the initial stages of the disability review process.

The Social Security Administration today has testified that there are essentially justified differences in the interpretation of the social security law and regulations. We agree. There is the Social Security Administration's interpretation and then there is the interpretation of almost everybody else.

There is the Federal court. There is now the GAO. There is Senator Heinz and now the Senate. There are provider organizations. There are the county commissions of mental health. There is NAC.

Therefore, we are very concerned that what SSA has asked is that they be allowed to implement the moratorium, that they be allowed, in consultation with provider organizations, which they claim to have already implemented—I will address that in a moment—that they be allowed to promulgate new rules—of course, not necessarily going through regulatory process or submission to Congress again.

We are concerned because we do not believe that, given the record of institutionalized prejudice, they will do this effectively. We don't believe it, and we are gravely concerned with the conflicting notion of what a moratorium means. We heard in response to your and others' questions today, that in effect, it means whatever SSA wants it to mean. We are concerned that our patients will continue to suffer from unreasonable CDI reviews and continue to be turned off the rolls.

Now, a few specific comments, and then I will stop; it is very late.

The listings need revision. There is no question that medical criteria over time, as to what constitutes a diagnosis, what constitutes an impairment—and that is just as true of psychiatry as it is of other fields—changes with time.

The view embodied in existing regulations is that mental illness, if it is not represented at the moment of the examination by the manifest persistence of symptoms, the patient does not meet or equal the listings.

That is unscientific and unreal in the light of modern psychiatry. I am not sure it was ever real. But it certainly is not justified at the present time. That must be changed.

Second, with respect to residual functional capacity, a patient's capacity to work, whether they meet the listings or not, has promulgated some reasonable general criteria. However, they have no operationalized approach to gathering data or to ascertaining from the patient's medical record material which actually assesses whether a human being can work or not.

That must be done. And until it is done, a moratorium is absolutely imperative. The criteria are too vague, and the mindset that was talked about just a few moments ago in the previous testimony will prevail.

And that mindset is going to continue to manifest itself as unfair terminations under CDI.

One other comment. Mr. Simmons testified that an M.D. with a subspecialty in psychiatry might do as well in doing evaluations as a psychiatrist. Well, that is possible, except I never heard of an M.D. with a subspecialty in psychiatry, just as I never heard of a psychiatrist with a subspecialty in surgery.

It is an interesting medical fiction. I don't know where he got it. It is deeply troubling. It really is again an attitudinal statement which basically ignores the real needs of this patient population.

If SSA is going to do consultations, it is in the future. They have not yet done so in any formal sense. The American Psychiatric Association, the American Psychological Association, the National Association of Social Work, the vocational counselors' groups, are available any minute, any day, any month of any year for counsultation.

Mr. Simmons testified today that such consultation was taking place. I am the official representative to those consultations of the American Psychiatric Association. I have not received one invitation to deal with SSA personnel on these issues.

Mr. **Shannon**. Let me say, Doctor, there are some people in this administration that I really do think need to consult with you.

Dr. **Meyerson**. Well, I don't know if I have that kind of time or ability.

In conclusion, whether current SSA personnel were the folks who designed the Edsel which we are now dealing with, they certainly put it on the assembly line and have manufactured it far beyond its original intention by the designers, a point you have made over and over again.

That they be allowed to institute the moratorium, until they are satisfied with the redesign, and then they will end the moratorium, and implement the redesign, is totally unacceptable.

As a citizen and as a psychiatrist and as a representative of the APA, we would much prefer to consult with the Members of Congress and staff who might work in implementing new legislation which is a product of open hearings. We hope you will continue to get citizen and provider and disabled person input in this process and that our recommendations will work their way into both law and changes in regulation.

Thank you for your time and attention.
[The prepared statement follows:]

STATEMENT OF THE AMERICAN PSYCHIATRIC ASSOCIATION, PRESENTED BY ARTHUR T. MEYERSON, M.D.

Chairman, and members of the Subcommittees, my name is Arthur T. Meyerson, M.D. I am Associate Professor and Vice Chairman of the Department of Psychiatry at Mount Sinai Medical School and Clinical Director for Psychiatry at the Mount Sinai Hospital.

On behalf of the American Psychiatric Association, a medical specialty society representing over 28,000 psychiatrists nationwide, and as chairman of the APA's Committee on Rehabilitation, I am pleased to present to the Subcommittees on Social Security and Public Assistance and Unemployment Compensation our views and concerns regarding the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs' current impact on the mentally ill and other mentally impaired citizens.

The APA continues to be very much aware that periodic review of disability cases, whether on the SSDI or SSI rolls, is necessary not only to reduce fraud and abuse, but also to confirm that SSDI/SSI beneficiaries continue to meet eligibility requirements and remain unable to work. The GAO report which prompted the 1980 Social Security Disability Amendments found that perhaps 20 percent of those then on the SSDI rolls were probably not eligible for such benefits. Regrettably, the Administration's current approach to this problem continues to focus on reducing Federal expenditures, rather than a policy consistent with both the letter and the spirit of the careful review mandated by those 1980 amendments. The state DDS termination rate is at 44.3 percent thus far in this Fiscal Year, far above the AGO's original estimates. The Administrative Law Judge reversal rate is upward of 60 percent. Taken together, these figures bear out our concern that the SSA reviews, both in terms of their actual conduct and the policy underlying them, are still conducted in a manner contrary to sound medical practice and sound professional clinical practice. Not only is the program administratively confusing and awkward for the beneficiaries, physicians, health and mental health professionals, state officials and judges involved with it, but it works a special hardship upon the mentally ill SSDI beneficiaries who, by virtue of their illness itself, are particularly vulnerable.

Our concerns were first expressed over a year ago by the APA in a letter to then Secretary Schweiker, then in last year's testimony before the Senate Finance Committee, in more recent testimony before the Senate Special Committee on Aging, and in comments on proposed revisions to the so-called "medical listings," the SSA's regulations regarding the determination of disability based on medical criteria alone. Further, we have met on numerous occasions with SSA officials, both formally and informally, regarding our concerns. Unfortunately, our concerns persist. While gratified by a number of Secretary Heckler's proposed changes in the SSDI program, we cannot agree with her statement that "we have no reason to believe that there have been any unjust findings" in the current SSDI determination and redetermination processes. We have found the process to be fraught with problems—some related to the determination process per se, some related to the standards underlying the review and others related to personnel issues.

In our considered judgment, draft legislation which has been introduced in substantially similar form by Mr. Shannon, a respected member of the Social Security Subcommittee, represents a serious and responsible means of recodifying current SSDI law (and similarly, SSI law) to assure that both fraud and abuse are eliminated from the SSDI and SSI rolls, and at the same time provides protection for those who should remain on or be placed on the rolls. The legislation addresses such issues as:

Accurate assessment of a person's ability to work;

Whether a person's medical condition had improved;

The use of appropriate personnel to make informed medical decisions regarding both a person's impairment and disability;

The need to update and improve existing existing medical criteria for the assessment of disability before further reviews are conducted;

The provision of a face-to-face meeting at the initial stages of the disability review process.

Others testifying at this hearing will address some of these issues, and will certainly address others which I have not identified. As a representative of the APA, I would like to address some of the process, standards and personnel issues with which I am particularly familiar, with which the APA and others have grappled for some time, and which are related to the medical assessment of impairment and determination of disability.

REGULATIONS/STANDARDS

As a physician, I am most seriously concerned with the *proper* interpretation of medical history in establishing a finding of disability. I am concerned about the accurate and complete development of that medical history, its interpretation into a statement regarding levels of impairment, and its ultimate relationship to a finding of disability. The APA, as a medical organization, has similar concerns. It was because of these concerns as they relate to the SSDI program and our belief that current medical understanding has yet to be applied to the medical and vocational assessment process under the SSDI program, that we recommended and sought the adoption of a moratorium on Continuing Disability Investigations for the mentally impaired. Such a moratorium would continue pending: a thorough rewrite of SSA's regulations surrounding mental impairment, a reconsideration and redevelopment of how vocational capacity is assessed for the mentally impaired, and a redetermination regarding the issue of medical improvement as a standard of assessing continuing disability.

The APA has also taken internal action to help assure that APA members understand how to provide full and necessary information in a medical history for the proper conduct of SSDI reviews (whether CDIs or initial claims). Our board of Trustees has just approved for publication a document for our members providing guidance on how best to provide case history material for SSDI and SSI reviews—what facts to include, whether judgments are relevant, when to amplify by example a particular medical point to assure clarity.

As we better educate our own members about the process and the nature of the reports requested of them by SSA, we are concerned that SSA is not educated to the flaws in its own standards—its regulations and policy interpretations—some of which have not been revised in almost a decade. Yet, these regulations and policy interpretations form the basis for the interpretation of that medical history into a finding of disability, and the subsequent decision regarding disability.

Secretary Heckler has taken a first step toward improving the situation. We applaud her decision, announced at her June 7 press conference, to place those suffering from organic brain syndrome into the category of the permanently disabled. We are pleased that she has agreed to place a moratorium on continuing disability investigations for those mentally impaired in the functional psychotic category, pending the recodification of the regulations governing this disorder.

However, the policy distinction between psychotic and nonpsychotic disorders does not seem medically appropriate. The nonpsychotic, the group excluded from the Secretary's moratorium, are being terminated from the rolls at a 62 percent rate, many erroneously. This group is also the most prone to suicide because of their severe depression. Secretary Heckler is apparently willing to revise the medical listing for judging psychotic disorders, but there is still no indication that the Department is willing to revise similarly the medical listings for the nonpsychotic and other categories of mentally impaired which we believe critical.

MEDICAL LISTINGS AND RESIDUAL FUNCTIONAL CAPACITY

The Medical Listings—or Listing of Impairments—is a list of conditions, signs and symptoms which are deemed by the Secretary to be so severe that their presence alone, without further evidence of inability to work, justifies a finding that an individual is entitled to disability benefits. If someone "meets or equals" the listings, he is held to be per se disabled. If he does not, the law requires that capacity to work be examined. I will discuss these in turn.

A year ago, the SSA republished the Listings in draft form for public comment. Regrettably, the draft makes no substantive changes in the mental impairment section, notwithstanding the publication over two years before of a new Diagnostic and Statistical Manual of Mental Disorders (DSM-III) which sets forth current psychiatric nomenclature. Thus, the terminology utilized in the Listings bears little resemblance to the nomenclature utilized in medical case histories of mentally ill SSDI recipients. SSA state claims examiners, in effect, are forced to "translate" case record statements to language contained in the regulations and POMs before they can begin the evaluation process. Since they are not trained in the psychiatric nomenclature, such translation is difficult if not impossible. Thus, case histories which are wholly complete may be found to be insufficient based on the discrepancies in terminology utilized. The only safeguard could be the professional medical staff in the state agency, but many are not trained psychiatrists and are therefore not current on DSM-III nomenclature.

The draft regulations posed yet other problems in their construction. The APA commented to SSA on the precise changes we recommended in the Medical Listings. These included: changes in the requirement that certain signs and symptoms be manifest at the time of the evaluation—not necessarily the case in most forms of mental illness which is characterized by intermittent persistence (Part A)—and a modification in the impairments which, in combination with the signs and symptoms, form the basis for a determination of medical disability (Part B).

Notwithstanding our comments, the regulations were not altered. Thus the same Listings—inappropriate listings—still control. Beneficiaries are still being inappropriately dropped from the rolls based on antiquated, medically unsound regulations.

The Listing has a number of mental sub-categories: functional psychotic disorders, functional non-pyschotic disorders, etc. which in and of themselves are not utilized in current psychiatric nomenclature. Within each of these categories, generally two (and in one case, three) sets of criteria must be met to qualify a beneficiary for disability based on the Listing alone.

The first set, the "A" section, generally deals with what are traditionally called signs and symptoms of acute mental illness or in the case of a functional psychotic disorder, psychotic mental illness. These signs and symptoms must have "manifest persistence," that is, be presently active and visible at the time of the review. These incude such symptoms or signs as depression, agitation, hallucination, etc.

The concept of "manifest persistence" of signs or symptoms would indicate that a patient must be manifesting psychiatric symptomology at the *moment* of the evaulation. Requiring that acute clinical signs be manifest at the time of the examination fails to assess fairly and adequately that mental illnesses are characterized by an intermittent pattern of symptoms and signs to recognize that overt symptoms and signs of mental illness may be controlled by medication. Moreover and most critical, the absence of signs or symptoms is a poor predictor of ability to work.

After such signs and symptoms are found to be manifestly persistent, the second set of criteria—the "B" section—is then reviewed. That section requires that a beneficiary meet three (or four, in the case of functional non-psychotic disorders) specific requirements relating to activities of daily living and social adjustment. Specifically, the beneficiary must demonstrate that in the case of functional psychosis, he has "persistence of marked restriction of daily activities and constriction of interests and seriously impaired ability to relate to other people" (and deterioration in personal habits for the functional non-psychotic).

Unfortunately, "B" is generally assessed either in a consultative examination or by claims examiners' review of records examining such questions as: Was the patient on time for appointments? Can he or she take tests? Was he or she well groomed, etc.? These questions do not say anything about a person's ability to work. They cannot form presumptive evidence of capacity to work. Indeed, claims examiners have been instructed to disregard any notes in a medical record of a treating physician regarding a patient's capacity to work based upon sound medical judgment.

A beneficiary must meet both "A" and "B" in order to be said to "meet or equal" the Medical Listings and therefore be determined to be disabled based on medical criteria alone. If he does not, the sequential evaluation requires a look at work capacity (residual functional capacity) and vocational factors which might disqualify a person from work. Regrettably, until a recent court decision, SSA policy has been to "deem" those mentally ill who do not meet or equal the Listings to be able to perform unskilled labor.

On January 25, 1982, the Regional Medical Advisor for the Chicago Region, Dr. Sandor Berendi, wrote that it is "practically impossible to meet the Listing . . . for any individual whose thought processes are not completely disorganized, is not blatantly psychotic, or is not having a psychiatric emergency requiring immediate hospitalization. . . ." Dr. Berendi, noted that ". . . in fact an individual may be committable due to mental illness according to the State's Mental Health Codes and yet found capable of 'unskilled work' utilizing our disability standards. . . ."

In a recent court appearance—on behalf of the plaintiffs in a Minnesota court case (in which Federal District Court Judge Larson ordered a preliminary injunction against SSA's policy of terminating those mentally ill disabled if they did not meet or equal the Medical Listings based on a belief that those not meeting or equalling the Listings were capable of performing unskilled labor)—I testified to the relative lack of utility of the current Medical Listings in determining ability to work in the psychiatrically disabled. In direct response to a question "Are the listings of mental impairment . . . sufficient to measure the ability of a psychiatric patient to work," I responded unequivocally that they were not.

I based that statement upon three basic lines of research and clinical findings. The work of Strauss and Carpenter and others would indicate that one must examine a patient for signs and symptoms of illness (Part A), then for their social security (Part B), and then for their capacity to work. They cannot be considered in unison. Rather they are separate axes in the determination of impairment, of disability.

There are patients who, over the course of an illness, may be without symptoms. In fact, some may even be without much social impairment. They can, for example, in a day hospital setting, socialize well with the staff, get themselves dressed in the morning and do their activities—but cannot work independently.

We have studies from Illinois which discuss the natural history of schizophrenia. They indicate that as you follow 100 to 200 patients in treatment manifesting early states of schizophrenia—manifesting signs and symptoms of the disorder—a full 60 to 70 percent of those patients will develop major vocational and social disabilities within two years. The three axes must be considered separately.

Secondly, over the past 20–25 years, we have accumulated a myriad of studies evaluating the use of anti-psychotic medications in controlling signs and symptoms. Of the over 20 drugs which have been introduced, many are very effective in controlling signs and symptoms such as agitation, hallucination, major depression. However, the bulk of data—30 to 40 studies, conservatively—show that while these drugs may be quite effective in controlling signs and symptoms, they do relatively little in terms of social or vocational adaptations, particularly the latter. Thus, you have many patients who may appear at an interview to have their symptoms controlled, and who may not meet either Part A or B and yet are vocationally disabled.

They very stress of trying to live independently and work at the same time may overwhelm many patients and they become sick again, despite the medication to control signs and symptoms. This is not the exception. It is the rule.

Third, studies at the Western Pennsylvania Psychiatric Institute at the University of Pittsburgh have shown that if you place a well-controlled schizophrenic on medication in a day program—not even a work situation, but a program designed to improve social and vocational functioning—anywhere from 15 to 25 percent of such patients will actually get worse. The stress of the program seeking to help them become socially and vocationally capable, actually causes them to decompensate—to get worse.

While this evidence has not been persuasive to SSA, it is the best evidence we have, and there is no evidence on the other side to suggest that the absence of signs and symptoms, coupled with social functioning and vocational capacity cannot be considered a *sine qua non* of the ability to work.

Perhaps it can be put in better graphic detail, if I provide an example. I see literally hundreds of patients over the course of a year or two. Many, suffering from psychotic illnesses, are on medication and have well controlled symptom pictures—they have no "A" criteria, and since you must meet A and B, are not considered to be per se disabled. Yet other patients fail to meet both the "A" and "B" criteria, and as long as they are not in a stressful situation and are on medication, have no active psychotic symptoms and seem to be able to "manage" many social situations. However, such persons under stress, even in the slightest way—a volunteer job in the hospital for example—decompensate rapidly. These patients are the rule rather than the exception.

Let me draw an anology here to the cardio-vascular patient. If you sit in a room with such a patient, there are many such patients who may be able to function—breathing at a normal rate, responding to questions. However, if you put them in even the least stressful situation, walk down the hall, walk down three steps (not three flights), there is shortness of breath and so on. If your criteria are viewed in the non-stress situation, you are measuring nothing.

Thus, in and of themselves, the Listings cannot and should not be viewed as a means of determining a person's ability to work—particularly a person suffering from a serious psychiatric disorder.

WORK EVALUATIONS

SSA's policy of utilizing the Listings as a means of ability to work has been halted in the Chicago region as the result of the Minnesota suit. It has been found by the Court that there are factors which more reliably predict whether a chronic mental patient can work. Where work is not obviously precluded by severe symptoms or other factors, analysis of recent prior work history, analysis of the reaction of the patient to stressful situations, and evaluation in a work setting or work-like setting can identify mentally impaired persons who, as a result of their illness, cannot work.

Yet, SSA resists the establishment of a better test of residual functional capacity. We do not argue with the criteria which have been established by SSA for evaluating capacity to work. We are, however, concerned that SSA has not articulated techniques for evaluating an individual's capacity to work against these criteria. The criteria alone do not permit adequate response. Capacity to work must be viewed within the context of present illness and treatment. A work-like evaluation can assess whether the skills a person was able to perform in the past when employed either can still be performed or that other work can be performed.

SSA has argued against workshop or work-like evaluations on the basis of cost. However, I would suggest that assessing whether a psychiatric patient has the capacity to work—to be either denied SSDI/SSI or terminated from the SSDI/SSI rolls—should not cost substantially more (and probably would be less) than some of the cardiac-pulmonary assessments required by SSDI for heart disease. If you add up the cost of electrocardiograms, scanographs, stress tests, physician's fees for all of that, and compare it to the cost of an adequate work assessment program, I would imagine that the latter is not as expensive.

The APA does not believe that every patient suffering from a psychiatric disorder and undergoing a CDI or initial SSDI review needs to go through an entire work assessment. There will be patients who obviously cannot work, based on the Listings—though as I have mentioned, these are very few in number. However, those applicants who fail to meet the Listings and for whom an evaluation of their work history, course of illness, history of stress tolerance, etc. does not lead to a finding of disability, should have the benefit of a work assessment before they can be terminated. We believe that absent other findings which would remove someone from the SSDI/SSI rolls, (such as current employment, substantial medical improvement, etc.), terminations based on capacity to work should only occur upon a full work evaluation. Such evaluations form an integral part of our previously cited legislative proposal which has been shared with the Committee.

MEDICAL IMPROVEMENT

Since 1979, the Social Security Administration has formally taken the position that disabled beneficiaries must establish that they continue to be disabled under the standards currently in use by the SSA. Under this approach, benefits can be terminated even if there is no evidence of medical improvement and, in many cases, even if the person's condition has actually deteriorated since the original determination of disability. No use is made of medical or other documentation which is over one year old. Thus, an individual who has been on the rolls for several years is treated the same as a new applicant. No weight is give to the original determination of disability, even though it was valid at the time rendered. While some courts have required the Secretary to continue benefits unless there is evidence that the person has medically improved or that the original decision was clearly erroneous (the most recent, a mere three weeks ago) SSA, relying on its non-acquiescence policy (also addressed in our draft legislation and the Shannon bill) has refused to apply this standard.

From a medical perspective, a medical improvement standard makes excellent sense. It assures that a full longitudinal look is taken at a patient's case history, and that there is substantial evidence contained in that record to justify a determination that the patient is no longer disabled. This is especially true for those suffering from mental impairments which are frequently subject to fluctuation or periodic remission. A single temporary fluctuation away from a profound psychosis, then, would not be sufficient to terminate such a beneficiary.

Further, a medical improvement standard which requires substantial evidence prior to termination assures that a physician's note that his patient had improved at a particular point in time will be reviewed against the patient's full record. Certainly there are instances in psychiatry where a physician would indicate that his patient had improved, yet when taken in conjunction with the prior history, it would show that the physician meant that the patient who prevously had hallucinated for eighteen hours of the day, now only hallucinates for sixteen. That is improvement, but not necessarily of sufficient magnitude to permit a person to perform substantial gainful activity. For that reason, we believe that the inclusion of a medical improvement standard which requires both substantial evidence and a finding that 'improvement' indicates an ability to work is critical.

This standard is medically sound from yet another perspective. It assures that if patient has benefitted from new medical techniques or technology which has allowed his or her previously disabling condition no longer to be disabling, he or she may be dropped from the rolls.

Coupled with the requirement in our draft legislation that SSA consider the complete medical and vocational history, including all evidence in the file from prior evaluations, and develop a complete medical history of the beneficiary covering the preceding twelve months, we believe a medical improvement standard will help assure that the intermittent and fluctuating nature of mental illness will not be used to the beneficiary's detriment in determining whether or not he should remain on the SSDI/SSI rolls. AS GAO noted in a 1982 report, "While the need for current evidence is obvious, we also believe there is a need for a historical perspective in these CDI cases. Many of these individuals coming under review have been receiving benefits for several years. To base a decision only on the recent examination . . . could give a false reading of that person's condition. This is especially true for those impairments subject to fluctuation or periodic remission, such as mental impairments."

PERSONNEL/CONSULTATIVE EXAMINATIONS

Yet another problem has been that the case records of SSDI beneficiaries have not been reviewed appropriately and accurately by state agency medical staff qualified to make an appropriate (if necessarily different from the claims examiner) judgment about a mentally ill patient. We know, for example, from a July 1982 letter from then Secretary Schweiker, following a meeting by the APA's Medical Director with the Secretary on the SSDI issue, that fully twenty-seven states did not at that time have sufficient numbers of psychiatrists on their medical staffs to perform appropriate reviews of mentally ill SSDI beneficiaries' records.

While the APA has undertaken a targeted effort across its District Branches to seek means of relieving this tremendous short-fall of personnel with some success in locating interested psychiatrists, to our knoweldge SSA has never informed DDS offices of our activities, and hence interested APA members have not yet been utilized in any significant way. This lack of meaningful SSA follow-up has not, of course, gone unnoticed by other interested psychiatrists who otherwise might have expressed further interest and participation.

In its recent report on the subject, GAO found that, in the five DDSs it visited, there were "no psychiatrists and limited psychiatric training was provided to examiners. Because the process encompasses a medical (psychiatric) evaluation that is highly complex, we asked SSA's psychiatrists whether a lay person or non-psychiatric physician had the expertise to make such an assessment. They said examiners would not be technically qualified nor would most physicians of other medical specialties. The chief medical consultant at one DDS said neither he nor the other staff doctors feel qualified to make a severity of psychiatric review form assessment.

Our proposal that each state agency hire psychiatrists or psychologists to assess mental impairment is critical. It is also entirely feasible. There are currently 28,000 APA members in the country, and perhaps as many as an additional 10,000 nonmember psychiatrists. Each state should be able to fulfill our propsoed requirement through full-time or part-time employment or consultative services of a psychiatrist or psychiatrists. States could even develop special relationships with teaching hospitals' and universities' departments of psychiatry, providing a mutually helpful relationship whereby psychiatric residents could provide their expertise in psychiatry, and at the same time learn about the disability program and its conduct.

We would also recommend that the Subcommittee review the existing fee rates established by the State aginst current competitive rates, with an eye toward establishing more approprite minimum fee rates which will be more conducive to hiring and retaining full or part itme physicians and consultants.

Similarly, we believe that more appropriate use of personnel performing consultative examinations needs to be made, and our legislative proposal addresses the quality and cost issues in this regard. Appropriately trained personnel to perform the CEs, and assuranes that the CEs are of sufficient length and depth to "capture" the nature of the patient's problem are both critical, particularly for the mentally impaired. We note that SSA has been conducting an experiment in New York and Georgia designed to respond to our concern regarding the value of consultative examinations for the mentally ill. While we are not cognizant of any effort to assure that the duration of the examination is of a more appropriate length (certainly they should be longer than fifteen minutes), we do know that SSA has, in those two states, implemented the practice of two consultative examinations, spaced several weeks apart. SSA has indicated that this has been implemented inan effort to ascertain whether such multiple consultative examinations may better "capture" the actual condition of the mentally ill SSDI applicant or recipient under CDI. We understand that these consultative examinations are scheduled approximately two weeks apart. We applaud SSA's attempt in this regard, but, as in their prior activities, we have concerns about the efficacy of this new mechanism, First, we are not certain that a two week span is sufficient to "capture" the changes and fluctuations in the medical as well as functional aspects of the mentally ill. Second, we are not certain that the beneficiary is seeking the same examiner on both occasions—something we believe should occur if the value of multiple consultative examinations is to be accrued.

Nonetheless, we are gratified by SSA's efforts to better manage the case development for the mentally ill SSDI beneficiary but believe that work in the way of personnel requirements is necessary.

THE PROCESS

Many of the severely mentally ill, the disabled capable of living in community-based settings as long as they receive proper therapeutic services, medication (if necessary), and social services to control their symptomology are unable to understand the meaning of a CDI review. They do not understand that their only source of income is being threatened, that their Medicare benefits (and/or Medicaid in the case of SSDI beneficiaries receiving SSI supplementation)—the source of payment for their continued treatment—is being threatened. They often do not understand the complexity of the forms they are asked to complete, or the necessity of such forms being completed in the first place. Further, given the nature of mental illness itself, it is often inappropriate, if not impossible, to receive an accurate self-evaluation from a mentally ill beneficiary. It is the very nature of the illness itself which cause a patient to deny or distort the medical significance of such illness. In a sense, much of what a mentally impaired individual may provide by way of narrative, either oral or written, is almost by definition going to be inaccurate, based on the nature of the illness itself.

While SSA has implemented a new procedure to help screen SSDI beneficiaries under CDI review by having them visit local SSA offices for evaluation and aid in completing their self-evaluation forms, how well that is working and what effect it can and will have on the mentally ill beneficiary remains to be seen. We do not know, for example, how "no shows" are handled—a frequent problem in the chronic mentally ill. The "profiles" developed by SSA to help local SSA offices screen out the obviously severely disabled, we understand, are themselves a problem. Are they appropriate "yardsticks" against which to measure? If someone is not a precise reflection of such profiles, yet is obviously disabled, what happens? What does the report of the local SSA office which is sent to the state DDS look like? What weight is it given? If the claimant is mentally disabled, how can the local SSA official appropriately and adequately advise that person of the procedures and the very nature of the CDI process itself?

Thus, while we view the new "interview" in the local SSA office as a generally positive gesture, we are hopeful that it is not just a gesture.

We believe that the proposal contained in our legislative proposal (and in the bill introduced by Mr. Shannon) to streamline the multi-level process has particular merit for the mentally impaired. The elimination of at least one step—reconsideration—and the movement of face-to-face meeting to the earliest steps in the process (at a beneficiary's request) makes good sense. Through such a face-to-face meeting, the initial State DDS adjudicator would best be able to explain to the applicant the basis for a preliminary decision to teminate or deny initial application. Often, physically and mentally impaired persons are easily discouraged and lack the capacity for sustained conflict and confrontation. The shortening of the process, the "uncomplicating" of the process, will remove what can best be described for some as an insurmountable obstacle. As Secretary Heckler announced at her press conference, the objective is to end the insensitivity of the existing process, to "humanize" the routine—we believe our proposal achieves that objective.

CONCLUSION

The APA is grateful to the Subcommittees today for giving us the opportunity to share our continuing concerns about the SSDI/SSI programs as they have been affecting the mentally impaired. Your efforts and those of your staff to work with the APA and other concerned organizations over the past months and weeks, we hope, well allow a substantial and meaningful reform of the SSDI/SSI programs. Our concerns are both immediate and more longranging. A moratorium on CDIs for the mentally impaired is critical. It will allow the time to set in place more appropriate regulations; it will allow Congress the time to adopt a unified, comprehensive reform proposal which will address the overarching questions of how to assess residual functional capacity, how to apply a medical improvement standard, how to simplify and streamline a confusing and complicated process, all without permitting SSA to continue to terminate disabled people from the SSDI rolls as the result of antiquated, medically inappropriate policies implemented from the Agency, not from Congressional mandate.

Also, in closing we ask that a June 23 letter to the APA's Medical Director from Secretary Heckler be made part of the hearing record. The Committees may be assured that the APA continues to be willing to work positively with the Secretary to meet all our mutual goals for improving policies and procedures respecting the SSDI program.

THE SECRETARY OF HEALTH AND HUMAN SERVICES,
Washington, D.C., June, 23, 1983.

MELVIN SABSHIN, M.D.,
Medical Director, American Psychiatric Association, 1400 K Street, NW., Washington, D.C.

DEAR DR. SABSHIN: This is in response to your recent letters concerning the willingness of the American Psychiatric Association to work with us on the revision of standards used in determining eligibility for the Disability Insurance program.

You can be sure that I have no higher priority than to see to it that any and all eligibility standards and policies in this program are reasonable and right.

I am gratified over the APA's willingness to work with us to that end as expressed in your June 10 letter. I hope that all other professional groups and associations will be equally willing to lend their expertise and support for this effort.

As you know, we are establishing joint working groups to address all policies and procedures that impact on eligibility decisions and the administrative climate in which they are made. The working group approach is the fastest means we have to bring outside experts together with Federal and State Disability officials.

We look forward to working with you and your colleagues in the weeks to come and I am confident that our mutual efforts will bring us closer to our mutual goals for this program.

Sincerely,

MARGARET M. HECKLER, *Secretary.*

Mr. SHANNON. Thank you very much.

Ms. Litz?

STATEMENT OF KAREN LITZ, MEMBER, PUBLIC POLICY COMMITTEE, NATIONAL MENTAL HEALTH ASSOCIATION, ACCOMPANIED BY CHRIS KOYANAGI, DIRECTOR OF FEDERAL RELATIONS

Ms. LITZ. We have also submitted our testimony for the record. I am Karen Litz. I am a member of the Public Policy Committee for the National Mental Health Association. In addition, I am also a member of the National Association of Social Workers and for 3 years chaired the Public Policy Committee for the National Council of Community Mental Health Centers.

Today, I am going to speak on behalf of the Mental Health Association and eight other mental health organizations.

I do have to put a personal note in here, because in addition to being involved as an advocate for the mentally ill for the past 12 years, for the past 3 years I have been the executive director of an Association for Retarded Citizens.

It was of interest to me to hear the county commissioner talk about the impact on local counties. There has been a tremendous impact on local voluntary agencies also, as a result of what the Social Security Administration has done.

Into my office every day come people who have lost their benefits, are about to lose their benefits, didn't realize anything was happening until the check didn't arrive, whom we now have to help.

We didn't get any more staff, and we didn't get any more money. But we are trying to help people who have lost their benefits or who are under the appeals process.

For the last 2 years, we have been increasingly concerned about mentally ill individuals who are unable to support themselves, but who at the same time are told they do not qualify for social security disability insurance or supplemental security income. This is due to changes in the way in which the Social Security Administration is processing claims under these programs.

Much publicity has been given to the continuing disability investigations. For the mentally ill, however, an equally severe problem is the change in the application of the criteria used to asses new applicants which has had a devastating effect on the chronically mentally ill people.

Without this essential source of income, many chronically mentally ill people are forced to remain in State institutions when they are in fact capable of more independent living in the community.

And I am sure the doctor can testify that it is much more cost-effective for all of us for people to be able to live in the community, plus the fact that it is better for them, too.

The information which has come to light over the last 6 months from the General Accounting Office, which you have heard, and from the suit filed by the Mental Health Association of Minnesota, shows that one fundamental problem is that no real assessment of an individual's ability to work is being made by SSA.

And this is something I see day in and day out. Persons who have been in sheltered employment or in a sheltered workshop are suddenly told that because of that experience they are capable of going out and competing for employment in the everyday work world.

In most cases, this certainly is untrue.

Other problems appear to be more generic, and have to do with the current operation of the adjudication system for all applicants and beneficiaries.

We have been working with a large coalition of both mental health and other disability groups. The changes we have worked on are now endorsed by 35 national organizations, and the over-100-member Save Our Security Coalition.

We strongly support, Congressman Shannon, your legislation that has been introduced as H.R. 2987.

We are very encouraged by the chairman and his staff, expressions of concern about the problem and they are willing to work with many of us and listen to our suggestions.

We believe that by working cooperatively, we can make the necessary adjustments to the program which will protect those who cannot support themselves, while still enabling Congress to continue to insure that periodic and appropriate reviews are made so that those no longer eligible can be removed from the rolls.

We do believe also that such individuals should be assisted and in the case of the persons that come to my office and the local

Mental Health Association offices, this is very true, that often they require assistance to understand what the process is all about.

They don't understand when that letter comes what that means. And they really don't understand until the checks stop coming and they cannot pay their rent what has happened to them.

They need help to more independent living, and we recommend for those who need it, appropriate rehabilitation services are available.

The changes proposed by the coalition fall into two categories, which you have heard from most of the other persons who have spoken today. Changes in standards, and changes in procedures.

Among the recommended changes in standards, the following are the most critical provisions for mentally ill persons.

Section 104, changes to insure accurate assessment of an individual's ability to work. Section 105, consideration given to noncompetitive work, section 205, assistance with reviews of continuing eligibility.

Section 207, qualifications of DDS-medical professionals. Section 303, continuing benefits for persons in vocational rehabilitation programs.

And section 305, trial work.

Among our recommendations for changes in procedual matters are section 101, standards of reviews to protect those now on the rolls who are being inappropriately terminated, section 102, multiple impairments, which you have heard a great deal about today.

Section 202, continuation of benefits through appeal. Section 204, case development and medical evidence. Section 301, uniform standards which are consistent with the law. And section 302, compliance with court orders.

I would also like to mention the moratorium which you have heard a lot about today.

We believe there is more than sufficient evidence to show that SSA is not using appropriate criteria, and that thousands of chronically mentally ill persons are losing their benefits inappropriately.

Until such time as the changes which this committee decides are needed can be made, no more reviews of mentally disabled persons should take place.

The cost to these individuals is simply too severe to justify continuing this policy. The severely disabled, especially those with mental illness, cannot protect themselves against the current inappropriate policies of the Social Security Administration.

The courts, the GAO, the thousands of horror stories documented by lawyers and the press clearly show we must act and we must act now.

These changes must be accomplished as soon as possible. The disabled people of the Nation deserve no less.

Thank you.

With me is a member of our staff, Dr. Koyanagi, to answer questions if necessary.

[The prepared statement follows:]

STATEMENT OF KAREN LITZ, MEMBER, PUBLIC POLICY COMMITTEE, NATIONAL MENTAL HEALTH ASSOCIATION ON BEHALF OF: AMERICAN ASSOCIATION OF PSYCHIATRIC SERVICES FOR CHILDREN, AMERICAN MENTAL HEALTH COUNSELLORS ASSOCIATION, AMERICAN PSYCHOLOGICAL ASSOCIATION, INTERNATIONAL ASSOCIATION OF PSYCHO-SOCIAL REHABILITATION SERVICES, NATIONAL ALLIANCE FOR THE MENTALLY ILL, NATIONAL ASSOCIATION OF SOCIAL WORKERS, NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS, NATIONAL COUNSEL OF COMMUNITY MENTAL HEALTH CENTERS, NATIONAL MENTAL HEALTH ASSOCIATION

This statement is presented on behalf of the above listed national organizations concerned with protecting benefits for disabled under Federal disability programs.

In March 1981, the Social Security Administration began an accelerated review of the claims of people receiving Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) benefits. Over the past year, thousands of severely disabled Americans who meet the requirements of the disability law and regulations have nonetheless been dropped from the disability rolls and left without any source of income for food, housing and medical care. Many are ending up homeless and destitute, on the rolls of hard-pressed state and local public-assistance programs or in public mental institutions.

The mentally disabled have been especially hard hit. Although only 11 percent of SSDI recipients are mentally disabled, they comprise 28 percent of people whose eligibility for disability insurance has been terminated (174,000 disabled persons across the country have already been terminated from the SSDI rolls). Often, cutoffs are the result of perfunctory reviews, using criteria irrelevant to employability and procedures which are beyond the capacity of many mentally disabled people to understand.

It has become increasingly difficult to establish eligibility for SSDI and SSI for those chronically mentally ill persons about to be discharged from state institutions. A number of states report increased difficulty in obtaining disability eligibility for mentally disabled clients who might leave the hospital and live in community homes or other supervised living arrangements in the community. Such community placements are far better for the patient, if sufficient health and other support services are available to them, as well as far less expensive. SSI eligibility plays a pivotal role in the process, particularly since it brings not only cash assistance, but eligibility for Medicaid.

Medical experts have testified to House and Senate committees that the stress of lost revenues and benefits have caused some mentally disabled individuals to be returned to hospital—at cross purposes with local efforts at deinstitutionalization—or put on other local public assistance programs.

Clearly mentally disabled persons are being denied essential benefits to which they are fully entitled and this is supported by the extremely high rate of reversal at the appeals level.

Of all those physically and mentally impaired who appeal to an independent Administrative Law Judge (ALJ), about two-thirds have their benefits restored. The General Accounting Office (GAO), using SSA records, found a reversal rate of 91 percent for mentally impaired persons who had their terminations reviewed by an ALJ between June 1981 and August 1982.

The basic problem for these psychiatrically disabled clients is that the Social Security Administration's procedures are extremely rigid and being applied in a very strict manner. Furthermore, these criteria are often never published for public review and comment and no public scrutiny ensures that the policy is fully compatible with the law and regulations.

That brings us to the major problem. Based on data from the SSDI redeterminations that have already taken place, and data from the SSI program, it is apparent that a significant number of psychiatric patients who clinically manifest an inability to engage in consistent substantial gainful activity are being denied disability benefits.

Witnesses at recent hearings before the Senate and House Aging Committee testified that standards used to take mentally disabled recipients off the rolls have been so strictly applied that even doing the simplest every day tasks—such as watching TV and fixing one's own meals—is considered sufficient evidence that an individual can go back to work.

In the case of Minnesota Mental Health Association v. Schweicker, decided in December 1982, Federal District Court Judge Larson found that SSA had used an illegal eligibility standard to determine claims of disability due to mental impairment. He found that state agencies were not making individualized determinations of ability to work as required by law and regulations. In short, Judge Larson concluded, "SSA has no medical, vocational or other empirical or scientific basis for presuming that a mentally impaired person whose condition does not meet or equal the Listings retains the residual functional capacity to work."

The General Accounting Office, after an eight-month review of the procedures in five state Disability Determination Services (DDS), one regional office and SSA headquarters, concluded that, with regard to persons with mental impairments, SSA had improperly cut off disability benefits for many individuals who had "little or no capability to function in a competitive work environment." GAO pointed out "we had 40 of the denial and termination cases reviewed by our clinical psychologist and she concluded that in 27 of the cases the individuals could not function in their daily living without support and could not work in a competitive or stressful environment. In an additional 13 cases she concluded that more medical or psychosocial information or trial work experiences were needed to make an informed decision."

One of the major problems of determining psychiatric disability is that patients do not always manifest their symptoms during the brief period of time that a medical consultant or SSA official is examining them. The Administration has forced reviewers to process claims too quickly to permit thorough examination of cases, and has put pressure on reviewers to deny benefits in most cases.

According to GAO investigators, regional workers conducting the reviews perceived a mandate from SSA of "deny, deny, deny." If there was any doubt about an individual's disability—especially difficult to determine for the mentally disabled—a negative decision often was handed down based on a cursory review of the individual's medical history. The GAO report identified specific weaknesses in SSA's adjudicative policies and practices. These included:

1. An overly restrictive interpretation of the criteria to meet SSA's medical listings, resulting principally from narrow assessments of individuals' daily activities;
2. Inadequate development and consideration of a person's residual functional capacity and vocational characteristics;
3. Inadequate development and use of existing medical evidence resulting in an over-reliance and misuse of consultative examinations; and
4. Insufficient psychiatric resources in most state disability determinaton service (DDS) offices.

In response to these and other major deficiencies in the current administration of the program a coalition of 36 National organizations concerned with protecting benefits for disabled persons is urging legislative action to protect the rights of disabled persons. Such reforms have been introduced by Congressman Shannon of this subcommittee as HR. 2987.

Our recommendations for legislative reforms are designed to correct the major weaknesses in the process found by the GAO, the federal court in Minnesota and thousands of disabled persons arbitrarily terminated from the DI and SSI rolls. The coalition recognizes that periodic reviews of non-permanent disability cases are necessary to confirm that beneficiaries remain unable to work. However, the callous and brutal administration of disability reviews must be stopped. Safeguards must be provided to ensure fair, accurate and humane reviews for all disability recipients, those with mental impairments as well as those with physical disabilities.

The proposals we recommend are of two types: (A) changes in standards for determining disability, and (B) changes in procedures for determining disability.

A. Changes in Standards:

1. An individual should not be terminated from disability unless his condition has improved, except where certain other conditions are met which indicate ability to work or where the original disability determination was based on fraud or clearly erroneous findings.
2. In determining whether the impairment or impairments are of such severity that the person is in fact disabled, SSA should consider the combined effect of all the individual's impairments even if none of the conditions considered separately would constitute an eligible disability.
3. Subjective evidence of pain, including statements of the individual as to intensity and persistence of pain and corroborating evidence by family, neighbors or behavior indicators, should be considered in determining whether an individual has a disability.
4. Work in a sheltered workshop or other non-competitive setting alone should not be considered sufficient evidence of ability to work in a competitive environment to result in termination of benefits.
5. A determination of the individual's ability to work should be based on a realistic evaluation of his capacity to meet the demands of a competitive work environment on a sustained basis. For mentally ill individuals with a severe impairment, a formal work evaluation should be required.

B. Changes in Procedures:

1. There should be a moratorium on reviews of mentally disabled persons until SSA demonstrates to Congres that appropriate procedures for assessing chronically mentally ill persons are in place.

2. The provisions of PL 97-455 relating to the continuation of cash benefits and Medicare eligibility through completion of the appeals process, scheduled to expire in October 1983, should be made permanent.

3. In cases in which the decision by the DDS is in whole or in part adverse to the disabled person, a pretermination notice should be sent to the individual advising him that he has a right to a personal appearance before the DDS at which he can present additional medical evidence or other information. Only after the person's appearance has occurred or the time allowed for a personal appearance has expired should the DDS issue a decision affirming, modifying or reversing its preliminary decision. Appeal of an unfavorable decision could be taken directly to an ALJ. The reconsideration level of review would be eliminated as an unnecessary and duplicative part of the process.

4. In determining whether a disability exists, SSA should consider all medical and vocational evidence, including evidence which formed the basis for the initial determination of disability and evidence used in all subsequent reviews. Special weight should be given to the medical records of the treating physican or other health professionals.

5. SSA should determine through personal contact whether mentally disabled persons require assistance in complying with SSA's intructions and, further, all hearings should be held in buildings that are reasonably accessible to handicapped persons.

6. Decisions on medical eligibility for disability must be made only by appropriately qualified professionals. For mentally impaired persons, a psychiatrist or psychologist should sign off on the medical determination.

7. SSA should be required to establish standards on the use of consultative examinations including appropriate qualifications of those performing consultative examinations and to establish mechanisms for monitoring the CE process. The reimbursement rate to be paid for such examinations should be consistent with Medicare reimbursements for comparable services.

8. The program instructions SSA issues to its employees and the states through rulings and the Program Operations manual (POMs) should be made consistent with the laws and regulations governing the disability program. POMs and rulings which have the effect of revising or modifying regulations should not take effect unless issued as regulations with an opportunity for public comment.

9. An advisory council should be established to advise the Secretary on the medical aspects of disability. In addition to representatives from professional health and medical organizations, the council should include representatives from consumer organizations.

These proposals, in HR 2987 will greatly assist the mentally disabled. In particular, the Social Security Administration must adequately evaluate the individual's ability to work. Instead, the agency has relied on inappropriate medical criteria to justify mistaken conclusions about ability to work.

Research relevant to the vocational functioning of the severely psychiatrically disabled has been reviewed and summarized by William Anthony, Ph.D., Boston University Research and Training Center. Over the last two decades dozens of articles pertaining to this subject matter have been published. These articles have appeared in a variety of professional journals. According to Anthony the findings from each of these articles evidence near unanimous support for one or more of the following points:

The best clinical predictors of future work performance are ratings of a person's work adjustment skills made in a workshop setting or a sheltered job site.

The best demographic predictor of future work performance is the persons prior employment history.

The best paper and pencil text predictor of future work performance are tests which measure a persons ego strength or self concept in the role of worker.

A significant predictor of future work performance is a person's ability to "get along" or function socially with others.

A poor predictor of future work performance is psychiatric symptomatology.

A poor predictor of future work performance is diagnostic category.

A poor predictor of future work performance are tests of intelligence, aptitudes, and personality.

There is little or no correlation between a person's ability to function in one particular environment (e.g., community setting) and that same person's ability to function in a different type of environment (e.g., a work environment).

There is little or no correlation between a person's symptomatology and functional skills.

A person's vocational functioning can be improved by means of rehabilitation skills training intervention.

In light of these findings, it is essential that a realistic evaluation of each claimant's ability to work be made. In the case of mentally disabled individuals, a work evaluation, performed either in an actual or simulated work site, should be required. Committee report language should make clear that an appropriate work evaluation includes:

An in-depth interview to obtain a detailed work, educational and social history of the person.

A comprehensive medical and psychological evaluation.

Vocational and work-sample testing to determine how the individual performs in an actual or simulated work setting and if he has skills to engage in SGA.

And, where a physical impairment exists or is suspected in addition to a mental impairment, and evaluation of physical capacity done by a licensed occupational therapist under the directions of a physician.

The Social Security Administration should also be prohibited from improperly equating the ability to do sheltered work with the ability to hold a competitive job. There is a substantial difference between success in a non-stressful, supportive workshop environment and success in the competitive job market. Insights about the individual's performance and capabilities could still be used to assist SSA in reaching a decision, but no one should be presumed to be capable of working simply by virtue of their participation in a non-competitive work environment.

Many individuals currently receiving disability benefits are not able to understand or read the instructions provided by the agency or are physically or mentally unable to comply with the instructions. These individuals should not be mistakenly cut from the program because they were unable to obey agency instructions. Instead an affirmative obligation should be placed upon the SSA to assure that an individual's mental or physical impairments which would prevent voluntary compliance are accommodated.

Recently it has become apparent that many critical medical decisions used to determine an individual's disability are made by professionals who are not trained in the appropriate specialty area. For example, physicians trained in internal medicine have been attempting to evaluate whether a mentally ill patient has the capacity to engage in competitive employment. Only qualified psychiatrists or psychologists are able to make such determinations. A requirement that medical evaluations and assessments of residual functional capacity for the mentally ill be made only by qualified psychiatrists or psychologists will help assure an accurate determination of each disabled individual's capacity for substantial gainful activity.

Other important changes for the mentally ill in H.R. 2984 include the following:

Individuals on the disability rolls frequently can benefit from vocational rehabilitation services, and such services assist these individuals to move off the rolls and into employment.

Within certain limitations, section 301 of the Disability Amendments of 1980 (P.L. 96-265) allows SSA to continue payments to beneficiaries whose disability ceases while they are participating in an approved vocational rehabilitation program. The limitations are: one, the individual was not expected to medically recover prior to the completion of the rehabilitation program and, two, the Secretary has determined that continuation of rehabilitation services will likely result in the individual leaving the disability rolls. We suggest eliminating the limiting conditions so that individuals whose disability ceases while they are participating in a VR program will continue to receive disability benefits during their participation, regardless of the expectation of recovery when rehabilitation services began. The program should also be expanded to include whatever vocational rehabilitation services may be reasonable and necessary to return the former beneficiary to work.

Also, language is needed to provide an incentive for rehabilitation agencies to participate in the program. Payment over cost should be available for successful rehabilitations to provide incentives to focus attention on the SSDI population. Even the best evaluation techniques do not guarantee 100 percent success, and if facilities are to accept the risk of nonsuccessful rehabilitations, there should be an incentive for doing so.

As now interpreted by SSA, the nine-month period of trial work required to demonstrate ability to engage in SGA can be accumulated over many months and a number of years. Recency of work or sustained work over several consecutive months is not a requirement in determining that an individual has met the trial work condition. Individual months of work accumulated over several years do not demonstrate capability to engage in SGA. The statute should require that trial work is recent and that the extent of the work period is sufficient to prove the individual is capable of sustained work.

In some situations in which a review has found an individual no longer eligible for disability benefits because of SGA derived through trial work periods, the individual has not been permitted to retain benefits during appeal. Since SSA has clearly misapplied the trial work provision, 97-455 should be amended to permit continued benefits during appeal in these situations.

H.R. 2987 provides that before a person's disability benefits can be terminated, there must be a finding supported by clear and convincing evidence that (a) there has been significant medical improvement which enables the person to perform substantial gainful activity, or (b) new medical evidence and a new assessment of residual functional capacity must show that the person has benefitted from advances in medical or vocational therapy or technology which has resulted in his ability to perform substantial gainful activity, or (c) the prior decision was clearly erroneous or fraudulently obtained, or (d) the person is currently performing substantial gainful activity.

Since 1979, the Social Security Administration has formally taken the position that disabled recipients must establish that they continue to be disabled under the standards currently in use by the Social Security Administration. Under this approach, benefits can be terminated even if there is no evidence of medical improvement and, in many cases, even if the person's condition has deteriorated since the original determination of disability. No use is made of medical or other documentation which is over one year old. Thus, an individual who has been on the rolls several years is treated the same as a new applicant. No weight is given to the original determination of disability even though it was valid at the time rendered. while some courts have required the Secretary to continue benefits unless there is evidence that the person has medically improved or that the original decision was clearly erroneous, SSA has refused to aply this standard. The amendment addresses the very profound needs of severely disabled individuals who are currently being terminated, despite lack of medical improvement. The amendment also responds to the legitimate concern that benefits which were improperly allowed originally should not be continued and addresses the effect which improved medical and vocational therapy and technology may have upon an individual's ability to perform substantial gainful activity. With regard to the latter, it expected that this section will only be applied where the individual has actual access to advances in technology or therapy.

The provisions in PL 97-455 relating to the continuation of benefits and Medicare eligibility through the ALJ hearing, should become permanent.

Even with the enactment of comprehensive corrective legislation this year, the inequities resulting from the disability review process will not be totally resolved by October 1, 1983, the expiration date for the continuation of benefits provision of PL 97-455. By October 1, there will remain many disabled persons who will be eligible to appeal a finding of non-disability by the DDS. Making permanent their eligibility for cash benefits and Medicare services during appeal will ensure that the terrible financial and emotional hardships suffered by disabled persons before enactment of PL 97-455 will not recur. In those situations in which the appeals council calls up for review an ALJ decision favorable to the disabled person, cash benefits and Medicare eligibility should also continue through completion of that review.

Serious questions have been raised about the inadequacy of the medical and vocational evidence collected by SSA to determine whether a person continues to be disabled. Of particular concern is SSA's failure to examine the history and course of the beneficiary's illness. In situations of long-term, chronic illness and particularly in the case of chronic mental illness which often follows an erratic course, SSA has mistakenly accepted temporary improvement as representing an end to the disability. This pattern of error results from SSA's practice of using medical evidence collected from a single consultative examination, performed by a doctor under contract to SSA who is unfamiliar with the beneficiary's illness and medical history. Medical evidence already in the file from prior evaluations of the beneficiary is often ignored.

SSA should undertake a more complete review of the individual's condition. Evidence from the treating physician who is familiar with the beneficiary's condition over time should be given preference over an evaluation by a consultant. Medical history included in the file from prior evaluations should be part of the decision making process. A 12-month medical history should be the standard requirement. These changes will help assure that eligibility for disability benefits is based on an accurate and valid medical history.

The words of Senator John Heinz form a fitting summary of our concern. Opening two days of hearings of his Senate Aging Committee on the DI program, Heinz characterized SSA's review process as a "virtual holocaust committed against the most vulnerable group of beneficiaries." We echo his conclusion that "Congress must take swift and conclusive action to prevent this national scandal from continuing."

Hundreds of horror stories have been documented as a result of the SSA's over zealous cuts of SSDI recipients, its ineffective review processes, and the perverted sense of goals—budgets over human lives. To help stop any further hardship to some of this country's most defenseless and most needy people, we urge the passage of a moratorium on reviews of the mentally disabled, as now required under the Heinz amendment to the Supplemental Appropriations bill, which should be accepted by the House and enacted as soon as possible.

Following that emergency action, we urge, the Committee to approve a comprehensive reform bill which incorporates changes along the lines of those in HR 2987.

NATIONAL ORGANIZATIONS ENDORSING THE AMENDMENTS TO SOCIAL SECURITY DISABILITY INSURANCE AND SUPPLEMENTAL SECURITY INCOME PROGRAMS PROPOSED BY A COALITION CONCERNED WITH PROTECTING BENEFITS FOR DISABLED PERSONS (HR 2987)

Save Our Security Coalition;
American Academy of Child Psychiatry;
American Academy of Physical Medicine and Rehabilitation;
American Association of Psychiatric Services for Children;
American Association of Retired Persons;
American Association of University Women;
American Association of Workers for the Blind;
American Congress of Rehabilitation Medicine;
American Foundation for the Blind;
American Mental Health Counselors Association;
American Psychiatric Association;
American Psycholsocial Association;
Association for Retarded Citizens;
Child Welfare League of America;
Epilepsy Foundation of America;
Goodwill Industries of America;
International Association of Psychosocial Rehabilitation Services;
National Alliance for the Mentally Ill;
National Association of Counties;
National Association of the Deaf;
National Association of Private Residential Facilities for the Mentally Retarded;
National Association of Retired Federal Employees;
National Association of Social Workers;
National Association of State Mental Health Program Directors;
National Association of State Mental Retardation Program Directors;
National Committee Against Mental Illness;
National Conference of Catholic Charities;
National Council of Community Mental Health Centers;
National Council of Senior Citizens;
National Easter Seal Society;
National Mental Health Association;
National Multiple Sclerosis Society;
National Society of Children and Adults with Autism;
Office of Public Policy, Women's Division, United Methodist Church;
Older Women's League;
Paralyzed Veterans of America;
United Auto Workers of America;
United Cerebral Palsy Associations, Inc.;
United Church of Christ, Office of Church in Society;
Women's Equity Action League.

Mr. **SHANNON**. Thank you very much for your testimony and also for your support of the bill, which I have introduced with Congressman Stark.

STATEMENT OF ELIZABETH M. BOGGS, PH. D., MEMBER, NATIONAL GOVERNMENTAL AFFAIRS COMMITTEE, ASSOCIATION FOR RETARDED CITIZENS OF THE UNITED STATES, REPRESENTING THE CONSORTIUM FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES, TASK FORCE ON SOCIAL SECURITY

Ms. BOGGS. Mr. Chairman, the consortium I represent certainly welcomes the assurance that this committee plans to move with all deliberate speed to address these problems and proceed in the near future to solve some of them.

We believe, however, that it is important that in addressing the CDI question, one not just blast the visible tip of the top of the iceberg, but rather, deal with the underlying problems of which the CDI problem is simply—not simply, but in fact—a symptom.

About 90 percent of the attention in this hearing has been given to the continuing disability investigations, the reexaminations. But it is probably only 25 percent of the total problem. The Commissioner mentioned this morning the preeffectuation reviews, which are only just now getting rolling in fiscal year 1983. Those are reviews of the initial determinations. If the same criteria, standards and procedures are applied to them as have been applied to the earlier investigations of continuing disability we will have additional problems, the documentation of which will not be available for another year or so, but the damage in the meantime will have been done.

I am sure we would all agree that an ounce of prevention is better than a pound of cure. If this committee had known of the hornet's nest it was stirring up with what appeared to be reasonable language it put into the amendments in 1980, it certainly would have preferred to prevent them rather than be dealing with them here.

For all of these reasons, we particularly welcome both the Shannon bill, 2987, and also Mr. Stark's own bill, 3074, which attempts to deal with the similar problems as they affect the disabled people who primarily rely on SSI as distinct from social security.

In particular, we support your moratorium provisions, because of those concerns that Mr. Cohen put forward this morning, in which he documented very clearly the problems of gearing up to changes in performance, and clearly, the performance has got to be changed. We would not wish this committee to feel that merely by appropriating money to authorize some additional new positions, that the problem would then be solved. The training of staff, the orientation of staff and of other people involved, consultants, experts, everybody else, does not happen overnight. Merely being a psychiatrist doesn't particularly give you expertise in this particular area.

So, we see the need for a moratorium, not only to get the criteria changed, but to get the procedures in place.

I think that we have to recognize that we have a complex situation, and that it is complex by its very nature, and that attempts to oversimplify it do not do anybody a service. That applies among other things to oversimplified and formalized application of the medical listings. The medical listings are indicators. They are not themselves what the law has specified as the basis for classification as disabled.

The criteria for disability are complicated, the procedures are complicated, and also the factors which determine such things as the variation in the award rate in any given year and the active caseload in any given year. Some of these factors may be superficial and ephemeral, but there are also underlying realities, objective factors which create fluctuations in the application rate and in other phenomena that relate to it.

And we believe that these have not been adequately addressed, and that the panic in the Congress and elsewhere in the late seventies may have arisen in part because people failed to analyze the multiplicity of factors that may have been contributing to the apparent rise in the rolls in the mid-seventies.

I was particularly impressed by this very helpful staff paper that was distributed this morning, Background and Issues, and I would like to quote two things from it—

> * * * because the growth of the program seemed to be out of control, considerable attention was focused on the reasons for this startling increase. While no definitive answer has ever been reached, most people concluded that the program must be paying benefits to people who should not be getting them or it would not cost so much.

Now, I am not denying for a moment that some people may have then and may even now be getting benefits inappropriately. But it seems unlikely that that was the major cause of the phenomenon that we saw; I have never seen an analysis, for example, which took account of the fact that the Vietnam veterans were the first combat veterans for whom military service was fully covered under social security. They came back, many of them had delayed effects which resulted in disability which became manifest in the mid-seventies, and they applied. Now, we don't know what the numerical extent of that was, but my guess is that, combined with other factors, which also happened to be swelling at the same time, it was a factor.

Some mention is made of SSI in the staff paper—the fact that it was also implemented during that period. In order to be eligible for SSI, the applicant must show that he has exhausted all his other entitlements, including his entitlements to social security. Some people found out for the first time they were entitled to social security disability by applying for SSI. If you think they should have known that, let me tell you that when I applied for widow's benefits, I was surprised to discover that on the basis of some rather sporadic employment, I was also entitled to minimum benefits as a retired worker.

So don't think everybody knows about his eligibility for benefits and will have applied for them. I think there were some DI eligibles coming out of the woodwork during that period because of SSI.

The 1972 amendments also had an effect. The younger workers, including those Vietnam veterans, were more readily entitled during that period. The committee worked to cut back on that in 1980. But it was there in the seventies.

In my opinion, the most important factor that was operative in the mid-seventies and still is to some extent operative is age specific. The most important age group among those receiving disability benefits from social security is the age group between 55 and 65. That group began to swell in the seventies as a result of the heightened birth rates back in the 1920's. Nobody seems to have really analyzed what the age specific demographic factors are that influence this outcome.

I call your attention to the fact, for example, that among people who are 62 to 64—who are eligible for early retirement if they seek it—the total number of people who are now receiving early retirement or receiving disability benefits in this same age group is increasing, and has been increasing for several years, but the number and the proportion of those who are getting disability benefits is declining. Thus we have a very interesting example of a particular age group in which the strictures on eligibility for disability are apparently having a very palpable, calculable effect.

I make all these points because people with developmental disabilities, the population group I am representing here, constitute a substantial subpopulation of the total disabled group, but one which has different demographic characteristics than the main body of people who become disabled because they get older and get rheumatism or arthritis or circulatory diseases. It has a different demography, and that demography is creating and is going to create an increase in the eligible population, in the subgroup of the developmentally disabled. If somebody takes a look at the statistics and suddenly get excited and decides that we have to suppress this group, we will be very much damaged: I would like to prevent that by being up front in this situation.

The people who are developmentally disabled are those with severe chronic disabilities which first become manifest during childhood and continue into what would ordinarily be the working years. The majority of them have complex, pervasive central nervous system involvement—CNS includes the brain—and that involvement is manifest in a combination of functional impairments, some of which are mental and some of which are physical. I don't need to go into it. But the question of multiple impairments is a case in point which we need to address as it affects people with disabilities of early onset.

From a demographic point of view, the developmentally disabled come on to the disability rolls as the disabled adult children of covered parents. The present award rate is highest in the age group 20 to 35. That is precisely the age group of the post-World War baby boom, which is maturing at this time. If you look carefully, you will see they are also precisely the age group who have parents of retiring age, whose numbers are also relatively large right now. So it is very easy to explain why we have a continuing increase in eligibility for the adult disabled child program at this time without having to adduce any kind of slackness or looseness or casualness or any such thing on anybody's part. There are objective explanations for this growth, and I want to bring it to your attention.

These people have been covered in this way, and appear in the statistics as dependents and survivors rather than as disabled workers—as a result of the actions of the Congress back in 1956, at the same time the disabled worker program was established. We have a history in this area, and the program has been extremely valuable. However, the benefits to which disabled adult children are eligible are by law less than the maximum benefits that would be available to those people if they worked as well and as diligently as their fathers. Consequently, a greater proportion of them also receive SSI. We have estimated that between 900,000 and 1 million developmentally disabled people are currently receiving SSI as disabled people or social security adult disabled child benefits or both. I won't go into the details of that but we have included some data in our statement.

In reviewing the Shannon bill, we believe that most of the threats to this particularly vulnerable group have been anticipated. We note with considerable approval that you have dealt with the disability determination process, not just CDI, in that draft legislation. However, we feel that because so much emphasis has been placed recently—and in this hearing as an example—on the most immediately critical and most dramatic results of the mass terminations brought about by the intensified CDI process, we are concerned that the Congress make sure that the administration is not encouraged or even permitted to perpetuate the injustices evident in the CDI process in the future by applying the same methods to the initial disability determination process.

The effects of doing that will be cumulative and much harder to document because the people affected will not be quite so aware of something that they never got, rather than something that was taken away from them.

I would like just to speak to a couple of points that are particularly relevent to our interests. For example, in your bill, Mr. Shannon, in section 201, you make clear that once erroneous disability determination is reversed, the findings should be made retroactive for all purposes. We emphasize the particular importance of that for our population, because to be eligible for adult disabled benefits, one has to be continuously disabled since childhood. If you put on the record in an erroneous way a period of nondisability, you will improperly destroy that proper record.

We also call attention to the problems of trial work, and the interpretation of that. In the material that was sent up to the committee by the Mental Health Law Project, in response to the very good questions that you submitted to them, Mr. Chairman, there is reference to some advice from the Social Security Administration to the effect that if you earn $75 a month during a trial work period, that counts as a month of work.

It seems to us that the very least you could expect is that a person would not be considered to have worked effectively if he was not able to work at a rate which would permit him to receive credit for social security contributions on the basis of the minimum amount which is necessary to have in covered earnings for a quarter. That works out at about $125 a month now. If you have $125 a month for three months, you can have a covered quarter. And it seems as though $75 a month is really an absurd measure for saying somebody has shown his capability to work during a trial work period.

But as the Mental Health Law Project demonstrated, that criterior tucked away somewhere in guidelines, and was not part of the official regulatory language with which most of us were familiar on the record.

Those are a few of the items with which we are concerned. And I stand ready to answer additional questions.

[The prepared statement follows:]

Statement of Elizabeth M. Boggs, Ph.D., Member, National Governmental Affairs Committee, Association for Retarded Citizens—United States, Presented on Behalf of: American Coalition of Citizens With Disabilities, American Foundation for the Blind, Association for Retarded Citizens, Epilepsy Foundation of America, Goodwill Industries of America, National Association of Mental Retardation Program Directors, National Association of Private Residential Facilities for the Mentally Retarded, National Easter Seal Society, National Mental Health Association, National Society for Children and Adults With Autism, United Cerebral Palsy Association, Inc.

INTRODUCTION

The Consortium for Citizens with Developmental Disabilities has an important interest in the pending bill H.R. 2987. This is a tightly crafted piece of legislation which well targets the many weaknesses recently revealed in the disability determination processes under titles II and XVI of the Social Security Act. We share the concerns of our organizations whose primary constituencies are composed of present or potential disabled workers. However, the nature of chronic disabilities which first become manifest during childhood and continue into what would ordinarily be the working years requires special recognition and special advocacy on behalf of those so handicapped.

Most persons with severe disabilities originating during the developmental period have medical, social and economic needs distinguishable from those persons who become disabled later in life and may qualify as "disabled workers." At the end of this statement we have appended a brief account of these differences together with some data which indicates something of the etiology and demography of this population insofar as it is identified within the OASDI and SSI systems. Because they enter their adult years already disabled, they seldom have a significant work history of their own. In 1957 Congress recognized that this population would be excluded from any coverage unless specific steps were taken to give them coverage on the earnings records of their covered parents. Thus, those disabled before age 22 usually come under the umbrella of social security as the dependents or survivors of their covered patents. Specifically, from 1956 on, unmarried adults disabled since childhood have been given the same benefits as minor children, provided that they meet the same disability test as is applied to disabled workers. More recently, with the advent of Supplemental Security Income, this same test of disability is applied to persons under 65 seeking a means tested income maintenance benefit as disabled adults or disabled minor children without regard to age at onset. Some 440,000 adults disabled in childhood receive social security benefits as the auxiliaries or survivors of covered workers (retired, deceased or disabled); some 230 thousand blind and disabled children receive SSI; and an estimated four to five hundred thousand adults who receive SSI have also been disabled in childhood. It is known that about 170 thousand of these receive both SSI and adult disabled child's social security benefits. This means we are reviewing matters of interest to between 900 thousand and a million developmentally disabled recipients of one or both types of benefits.

These persons obviously have an interest in the continuing disability investigations; in addition we must consider the interests of those who are potentially eligible. In the Social Security component, which has stabilized over its 25 year history, the accession rate is about seven and one half percent or 33 thousand a year—not large by standards of the entire system, but vital to those directly affected, to parents as well as their adult sons or daughters. We are aware that the availability of these benefits has in many instances been critical in permitting a young adult to choose an independent living arrangement or alternatively to maintaining the dependent adult within a family.

Initial Determinations—A Continuing Danger Zone

In reviewing the Shannon bill, we believe that most of the threats to this particularly vulnerable group have been anticipated. However, because so much emphasis has been placed on the most immediately critical and most dramatic results of the mass terminations brought about by the intensified CDI process, we are concerned that Congress make sure that the Administration is not permitted to perpetrate similar injustices in the future on those undergoing initial disability determinations, whether for disability benefits, for adult disabled child's benefits, or SSI benefits based on disability. It would be easy for the Social Security Administration to interpret the legislative history of this bill as reflecting a stance reactive to the CDI intensification only; we hope you will use report language to underline those provisions in the bill which apply equally to new applicants.

Assistance to Beneficiaries and Applicants With Impaired Coping Skills

The legislation focuses on the need to make sure that potential or actual recipients are properly advised and assisted in obtaining benefits to which they are entitled. It may be desirable to emphasize that wherever reference is made to notice, or assistance, or opportunity for a personal appearance it is understood that guardians or representative payees, or next of kin are to be notified or advised, or permitted to appear, as appropriate, and that this outreach should be extended to initial applicants as well as those subject to CDI. It appears to us to be the intent and practice of the Social Security Administration to work through such persons if they are formally appointed but a caveat may be in order so as to assure that the intent of these provisions is to be achieved. We need a fail safe mechanism to protect persons who are impaired in their ability to advocate vigorously for themselves because of the very disabilities which should entitle them to benefits.

Reinstatement Retroactivity

We note with approval Section 201, items (4), (5) and (6) as these are of particular concern to persons with developmental disabilities. In order to be eligible for adult disabled child's benefits the applicant must have been continuously disabled since childhood. For this reason an erroneous determination of "not disabled" if entered in the records (perhaps in connection with an application for SSI) and not expunged could well jeopardize the individuals' entitlements to survivor's benefits at a later date.

Work Training and Work Potential; Transition to Employment

In recent years a number of research studies have reinforced the notion that under certain circumstances and with extended training many persons with substantial developmental disabilities may become quite productive. However, the consequenses of losing benefits, especially medical benefits, as a result of demonstrating "substantial gainful activity" are especially devastating for many developmentally disabled people because they so frequently find themselves in the marginal labor market without reliable substantive fringe benefit packages. Therefore it is especially critical that they receive the advantages which the Congress intended to extend through its provisions for a trial work period. We see two ways in which this concept must be strengthened:

(1) "Work" which is performed as part of a rehabilitation program (not limited to programs conducted under the auspices of state vocational rehabilitation agencies) must not be counted as part of "trial" work.

(2) A month of "trial work" must be one in which earnings are such that they equal at least that rate which—if annualized—would entitle the "worker" to four quarters of primary coverage under Title II.

As you will see the Social Security Administration guidelines quoted by the Mental Health Law Project do not meet the latter standard.

The issue with respect to "rehabilitation" is illustrated by a case which was pursued by the Community Health Law Project of East Orange, New Jersey; their summary is attached to this statement. You will note that two and one half years were required to vindicate "Mr. D." and that he won at the Appeals Council level. Notwithstanding that fact, the application of the principle upheld is considered to be limited to the local jurisdiction.

Special Concerns for Persons with Developmental Disabilities Who Are or Should Be Eligible for SSI

About 35 percent of the adult disabled child beneficiaries also receive SSI benefits. This is a measure of their low Title II benefit levels. These are doubly limited—directly by statute (50 percent of parental PIA for auxiliaries, 75 percent for survivors) and indirectly by the workings of the maximum family benefit. If the disabled person is one of three persons drawing on the record his benefit may be cut to 25 percent—37 percent of the PIA. Thus, of the 900 thousand to 1 million developmentally disabled persons dependent on Title II and Title XVI only about one third do not depend at least partly on SSI.

We also are very supportive of H.R. 3074, the "Supplemental Security Income Mental Disability Determinations Reform Act of 1983," introduced on May 19, 1983 by Representative Fortney Stark. In addition to placing a temporary moratorium on the continuing disability investigations of Supplemental Security Income disability beneficiaries having mental impairments, H.R. 3074 contains provisions which:

1. make permanent those sections of the Social Security Act which provide for the continuation of special cash assistance and Medicaid coverage for disabled SSI recipients who are able to work in spite of their disability;
2. require the continuation of benefits during the appeals process; and
3. require SSA to determine through personal contact whether mentally disabled persons require assistance in complying with SSA's instructions and procedures under the SSI program.

Prior to 1980, disabled SSI recipients who had gained skills which would seem to indicate readiness to enter employment faced a tremendous disincentive, i.e., the loss of their SSI benefit as well as their medical benefits. Section 201(d) of the Social Security Disability Amendments of 1983 virtually eliminated this work disincentive. Now, disabled SSI recipients who attempt work may do so without fear of a total loss of benefits, but rather with the knowledge that income and medical support will be available as they make their transition to a more self-sufficient life style.

Current SSA practice, based on court order, provides for a continuation of SSI benefits during the appeals process. We strongly support incorporating this practice into Social Security law. We believe that individuals who decide to exercise their appeal rights are entitled to a continuation of benefits as a matter of equity. The continuation of benefits recognizes that a final decision has not been rendered and increases the individual's ability to exercise his appeal rights fully.

ATTACHMENT A

SOME CHARACTERISTICS OF PERSONS WITH DEVELOPMENTAL DISABILITIES

Generally speaking, developmental disabilities are those severe chronic disabilities which are first manifest early in life—technically before age 22. The causes and character of such disabilities are significantly different from the disabilities which are most typical of those becoming disabled in middle age (45–64) or later. In the latter group heart disease, cancer, stroke and emphysema play the most important roles. By contrast among the developmentally disabled the most important causes of severe persistent disabilities are congenital anomalies, perinatal disease or trauma (such as anoxia at birth and various deprivations or accident occurring in the preschool years). In diagnostic terms the principal causes are mental retardation "moderate" to "profound," cerebral palsy, autism or childhood schizophrenia, and epilepsy. Historical data from SSA records shows that mental retardation as a primary diagnosis accounts for more than half of long-term work disability originating before age 18. This distribution is corroborated by more recent data on the SSI disabled child population (see tables attached). At present the contribution of spina bifida is increasing while the role of polio is decreasing; most polio survivors are now over 30. In addition, sports and auto accidents are adding to the total number of young adults who are paralyzed; severe brain damage from "near drowning" is also becoming an ominous concern. Severe vision, hearing and language disorders also contribute. Almost all of these are associated with generalized or localized pre or postnatal damage to the immature central nervous system and tend to have pervasive effects.

The social and economic effects of early disability are also destructive. A seriously disabled child has a different educational experience than the person who has learned to speak or read or adapt his behavior in the normal way. Unlike the disabled worker, the developmentally disabled adult does not have a work record in normal employment, hence no workmen's compensation or work-related medical insurance.

The attached tables from recent SSA publications illustrate some of the differences between this population and "typical" disabled adults.

ATTACHMENT A
Page 3

Table 66.—Benefits awarded and in current-payment status for individuals: Number and average monthly benefit amount, by type of beneficiary, race,[1] age, and sex, 1979—Continued

Age	Awarded during year		In current-payment status at end of year							
			Total		White		Black		Other	
	Number	Average monthly amount [3]	Number [4]	Average monthly amount	Number	Average monthly amount	Number	Average monthly amount	Number	Average monthly amount
Disabled children aged 18 and over	33,419	....	435,338	....	376,330	....	52,030	....	6,978	....
18-19	6,189	....	12,610	....	9,676	....	2,613	....	321	....
20-24	8,775	....	57,333	....	43,513	....	12,398	....	1,422	....
25-29	6,247	....	60,427	....	48,965	....	10,079	....	1,383	....
30-34	5,099	....	60,333	....	51,996	....	7,249	....	1,088	....
35-39	3,736	....	56,433	....	49,922	....	5,676	....	835	....
40-44	1,790	....	47,401	....	42,476	....	4,250	....	675	....
45-49	676	....	41,336	....	37,307	....	3,546	....	483	....
50-54	400	....	36,068	....	33,058	....	2,650	....	360	....
55-59	304	....	28,414	....	26,375	....	1,801	....	238	....
60 and over	203	....	34,983	....	33,042	....	1,768	....	173	....
CHILDREN OF RETIRED WORKERS	247,800	$132.30	652,002	$119.20	486,869	$128.40	123,964	$94.70	41,169	$84.00
Disabled children aged 18 and over	15,967	144.30	137,185	137.10	120,254	141.00	13,929	108.50	3,002	113.20
18-19	1,473	116.70	2,848	119.00	2,247	125.60	507	94.30	94	96.30
20-24	3,294	134.30	14,951	128.40	11,926	134.70	2,515	104.50	510	99.00
25-29	3,506	144.60	20,231	136.90	17,030	141.80	2,613	110.40	588	111.00
30-34	3,280	153.40	23,508	141.00	20,781	145.00	2,176	109.40	551	116.50
35-39	2,624	155.80	23,714	144.50	21,394	147.60	1,873	113.90	447	125.30
40-44	1,256	158.30	19,350	141.30	17,482	144.00	1,504	115.00	364	119.10
45-49	337	146.10	14,247	135.50	12,792	138.50	1,232	108.00	223	116.60
50-54	129	129.70	9,592	132.80	8,659	135.60	807	106.30	126	114.10
55-59	42	121.00	5,359	127.40	4,855	130.00	439	100.60	65	118.10
60 and over	26	118.00	3,385	121.50	3,088	123.90	263	94.70	34	104.30
CHILDREN OF DECEASED WORKERS	544,549	208.60	2,710,837	205.60	2,060,081	218.60	572,818	164.50	77,938	161.20
Disabled children aged 18 and over	10,999	198.60	265,890	195.90	230,049	200.30	32,541	165.20	3,300	173.60
18-19	3,054	188.50	6,753	195.30	5,049	209.80	1,546	151.90	158	158.30
20-24	3,241	194.30	30,241	200.30	22,257	212.50	7,361	166.50	623	165.20
25-29	1,647	213.20	31,746	207.40	25,022	216.80	6,120	172.30	604	176.70
30-34	1,103	221.00	31,619	205.90	26,762	212.70	4,397	167.90	460	179.50
35-39	695	226.80	30,134	205.10	26,301	210.40	3,485	167.00	348	187.10
40-44	375	201.30	27,294	200.40	24,361	204.30	2,630	165.70	303	182.10
45-49	277	184.80	26,999	195.40	24,444	198.60	2,296	164.00	259	173.00
50-54	212	167.40	26,460	190.00	24,387	192.50	1,839	160.10	234	167.90
55-59	224	161.90	23,050	183.70	21,516	185.60	1,362	155.70	172	168.70
60 and over	171	163.40	31,394	171.60	29,950	172.90	1,505	147.80	139	160.50
CHILDREN OF DISABLED WORKERS	399,172	105.50	1,431,324	95.20	1,100,242	100.30	290,483	79.40	40,599	68.90
Disabled children aged 18 and over	6,453	116.70	32,263	117.70	26,027	123.40	5,560	94.30	676	90.10
18-19	1,662	98.10	3,009	102.40	2,380	108.00	560	81.20	69	81.10
20-24	2,240	110.10	12,141	108.38	9,330	114.10	2,572	90.00	289	82.10
25-29	1,094	127.50	8,450	121.00	6,913	126.20	1,346	97.70	191	94.60
30-34	716	134.80	5,206	129.80	4,453	134.50	676	101.80	77	104.20
35-39	417	143.60	2,585	137.40	2,227	141.80	318	109.90	40	110.30
40 and over	324	138.40	872	136.80	724	141.00	138	118.30	10	87.60

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ATTACHMENT A
Page 4

Table Q-9.--OASDI cash benefits: Number and amount of monthly benefits in current-payment status for children 1940-82

At end of selected month	Number of children of—				Amount (in thousands) for children of—			
	All workers	Retired workers	Deceased workers	Disabled workers	All workers	Retired workers	Deceased workers	Disabled workers
	Persons aged 18 and over with childhood disability							
December:								
1957	28,869	16,686	12,183	...	$1,116	$526	$589	...
1960	104,054	53,825	47,267	2,962	4,594	1,922	2,557	$115
1965	198,390	87,122	102,287	8,981	10,271	3,541	6,357	374
1970	270,557	101,341	154,921	14,295	19,806	5,755	13,290	761
1975	362,295	124,328	213,756	24,211	44,492	11,993	30,459	2,039
1978	419,897	134,726	253,586	31,585	64,520	16,502	44,689	3,330
1979	435,346	138,756	264,327	32,263	74,682	19,106	51,780	3,796
1980	450,332	142,204	275,430	32,898	89,642	22,820	62,347	4,475
1981	463,021	143,633	286,724	32,664	103,951	26,173	72,816	4,962
1982	472,416	145,339	296,850	30,027	115,773	28,974	81,877	4,922
1982								
March	464,697	143,886	288,851	31,960	104,814	26,346	73,626	4,842
June	466,855	143,646	291,471	31,738	[1] 113,773	[1] 28,395	[1] 80,160	[1] 5,218
September	468,348	144,174	293,842	30,332	[1] 114,711	[1] 28,622	[1] 81,060	[1] 5,029
December	472,416	145,339	296,850	30,027	115,773	28,974	81,877	4,922

[1] Represents amount before final rounding of benefits.

Disabled adult child beneficiaries receiving concurrent SSI payments - December 1981

Receiving Title II DAC benefits

As children of retired workers	143,633
concurrent SSI %	45.3%
As children of disabled workers	32,664
concurrent SSI %	58.2%
As survivors of deceased workers	286,724
concurrent SSI %	30.2%
Total Receiving Benefits	463,021
concurrent SSI %	34.7%

From Table 170 SSB - Annual Statistical Supplement 1981

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ATTACHMENT A
Page 5

Table 173 (1980).—Supplemental Security Income: Number and percentage distribution of blind and disabled children receiving federally administered payments, by age, December 1980

Age	Total	Blind	Disabled
Total number	228,564	6,853	221,711
Total percent	100.0	100.0	100.0
Under 5	11.7	14.6	11.6
5-9	20.9	21.8	20.9
10-14	28.8	27.6	28.8
15-17	21.7	19.5	21.8
18 or older	16.8	16.4	16.8

Table 172.—Supplemental Security Income: Number and percentage of all adults receiving federally administered payments, by reason for eligibility and age, December 1981 [1]

Age	Total	Aged	Blind	Disabled
Total number	3,788,781	1,678,090	71,463	2,039,228
Total percent	100.0	100.0	100.0	100.0
18-21	2.3	....	4.5	4.1
22-29	7.2	....	13.9	12.8
30-39	6.8	....	11.4	12.2
40-49	6.8	....	10.2	12.2
50-59	12.5	....	16.2	22.6
60-64	8.5	....	10.1	15.4
65-69	13.5	13.5	10.1	13.7
70-74	14.4	24.3	8.0	6.4
75-79	12.0	26.5	5.1	.3
80 or older	16.0	35.6	10.5	.1

[1] Of the 230,094 blind and disabled children, 84.7 percent were under age 18 and 15.3 were aged 18-21.

Table 174.—Supplemental Security Income: Number and percent of persons receiving federally administered payments and with representative payee, by reason for eligibility, December 1980

Reason for eligibility	Total number	With representative payee	
		Number	Percent of total
Total	4,142,017	789,272	19.1
Adults	3,913,453	574,961	14.7
Aged	1,807,776	81,163	4.5
Blind	71,548	7,301	10.2
Disabled	2,034,129	486,497	23.9
Blind and disabled children	228,564	214,311	93.8

Social Security Bulletin, Annual Statistical Supplement, 1981

Supplemental Security Income Data on Age and Personal Dependency

Social Security Bulletin, June 1983/Vol. 46, No. 6

Table Q-26.—SSI: Number and percentage distribution of adults receiving federally administered payments, by reason for eligibility and age, December 1982 [1]

Age	Total	Reason for eligibility		
		Aged	Blind	Disabled
Total number	3,628,439	1,548,741	70,157	[illegible]
Total percent	100.0	100.0	100.0	100.0
18-21	2.3	...	4.5	4.0
22-29	7.5	...	13.9	13.0
30-39	7.2	...	12.3	17.6
40-49	6.9	...	10.1	12.0
50-59	12.2	...	15.7	21.5
60-64	8.5	...	10.2	14.9
65-69	12.8	12.5	9.6	13.1
70-74	14.2	22.4	8.4	8.1
75-79	12.1	27.6	5.1	.5
80 or older	16.3	37.5	10.2	.1

[1] Of the 229,151 blind and disabled children, 83.6 percent were under age 18 and 16.4 were aged 18-21.

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Table 178.—Supplemental Security Income: Number and percentage distribution of blind and disabled adults initially awarded federally administered payments, by basis for adjudication and diagnostic group, 1977

Diagnostic group	International code[1]	Total[2]	Impairment: Meets level of severity	Impairment: Equals level of severity	Medical or vocational consideration[3]
Total number	....	288,904	115,075	108,607	65,222
Total percent	....	100.0	[4] 100.0	[4] 100.0	[4] 100.0
Infective and parasitic diseases	000-136	1.3	1.8	1.3	.6
Neoplasms	140-239	6.4	9.1	6.8	1.2
Endocrine, nutritional, and metabolic diseases	240-279	4.4	3.5	3.9	6.7
Mental disorders	290-315	31.1	37.1	34.7	14.7
Mental retardation	310-315	13.4	21.5	9.5	6.2
Diseases of the—					
Nervous system and sense organs	320-389	10.1	14.5	8.6	4.6
Eye	360-379	2.7	5.4	.7	1.5
Circulatory system	390-458	20.3	16.5	30.4	26.7
Respiratory system	460-519	4.6	4.6	3.1	7.2
Digestive system	520-577	2.0	1.9	2.3	1.8
Genitourinary system	580-629	.9	1.2	.8	.4
Musculoskeletal system and connective tissue	710-738	11.1	2.4	7.4	29.3
Congenital anomalies	740-759	1.4	1.6	1.5	1.1
Accidents, poisonings, and violence (nature of injury)	800-999	3.8	3.4	4.4	3.7
Other	....	2.4	2.4	2.8	1.9

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[1] Based on International Classification of Diseases, Adapted, vol. 1, eighth revision (1969).

[2] Excludes those previously entitled to OASDI benefits.

[3] Includes 841 awards based on medical and vocational consideration (older and unskilled worker).

[4] Data based on SSA-831 file coded in SSA central office.

Table 179.—Supplemental Security Income: Number and percentage distribution of blind and disabled adults and children initially awarded federally administered payments, by diagnostic group, 1977

Diagnostic group	International code[1]	Number: Total[2]	Number: Blind and disabled: Adults	Number: Blind and disabled: Children	Percentage distribution: Total	Percentage distribution: Blind and disabled: Adults	Percentage distribution: Blind and disabled: Children
Total	....	335,783	288,904	46,879	100.0	100.0	100.0
Infective and parasitic diseases	000-136	4,190	3,871	319	1.2	1.3	.7
Neoplasms	140-239	19,650	18,605	1,045	5.9	6.4	2.2
Endocrine, nutritional, and metabolic diseases	240-279	13,476	12,712	764	4.0	4.4	1.6
Mental disorders	290-315	117,609	89,936	27,673	35.0	31.1	59.0
Mental retardation	310-315	63,981	38,713	25,268	19.1	13.4	53.9
Diseases of the—							
Nervous system and sense organs	320-389	37,951	29,035	8,916	11.3	10.1	19.0
Eye	360-379	8,738	7,800	938	2.6	2.7	2.0
Circulatory system	390-458	58,922	58,561	361	17.5	20.3	.8
Respiratory system	460-519	13,651	13,318	333	4.1	4.6	.7
Digestive system	520-577	6,021	5,894	127	1.8	2.0	.3
Genitourinary system	580-629	2,794	2,513	281	.8	.9	.6
Musculoskeletal system and connective tissue	710-738	32,834	32,126	708	9.8	11.1	1.5
Congenital anomalies	740-759	8,168	4,160	4,008	2.4	1.4	8.5
Accidents, poisonings, and violence (nature of injury)	800-999	11,774	11,094	680	3.5	3.8	1.4
Other	....	8,742	7,078	1,664	2.6	2.4	3.6

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[1] Based on International Classification of Diseases, Adapted, vol. 1, eighth revision (1969).

[2] Excludes those previously entitled to OASDI benefits. Data do not add to total because of rounding of estimates to integral values.

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ATTACHMENT B

TRANSITIONAL EMPLOYMENT VERSUS TRIAL WORK—A CASE REPORTED BY THE COMMUNITY HEALTH LAW PROJECT—EAST ORANGE, NEW JERSEY

In May 1980, Mr. D. completed seven months in a transitional employment position and began full-time employment at the same employer. Mr. D. notified Social Security that he had begun full-time employment and expected to receive a nine-month trial work period before his Social Security Disability benefits were put in jeopardy of termination. Needless to say, Mr. D. eventually received a letter from Social Security claiming that he had been overpaid more than $900. In order to arrive at this conclusion Social Security had counted Mr. D's participation in transitional employment as part of his trial work period. The Community Health Law Project filed an appeal for Mr. D. and the issue was clear: If transitional employment is considered part of a trial work program, then Mr. D. was overpaid. However, if transitional employment is not trial work, then Mr. D. had not been overpaid, and he did not owe anything to Social Security.

While the question of what is transitional employment has arisen on many occasions when Law Project staff have worked with Prospect House clients, this was perhaps the first time that there were no other issues to cloud the determination. While clients engaged in transitional employment had successfully avoided termination of benefits, none of these cases resulted in a written opinion indicating that there was anything unique or special about a transitional employment program.

Social Security regulations (20 C.F.R. 404.1592) provide that a trial work period occurs when "services" are performed by the disabled individual. "Services" is defined as "any activity, even though it is not substantial gainful activity, which is done by a person in employment or self-employment for pay or profit, or is the kind normally done for pay or profit." However, work is not to be considered "services" when "it is done without remuneration or merely as therapy or training, or when it is work usually done in a daily routine around the house, or in self-care.

Using the carefully prepared materials from Prospect House explaining the purpose and structure of transitional employment, Law Project staff attempted to convince the Administrative Law Judge that transitional employment was not a work situation, but rather a comprehensive rehabilitation program. Mr. D. was extensively questioned about the differences between his transitional employment position and his current competitive employment position. While never specifically addressing the issue, the Administrative Law Judge treated transitional employment as regular employment and found that Mr. D. was overpaid.

On Appeal to the Appeals Council, however, the result was significantly different. The Appeals Council specifically found that Mr. D's work activity was performed primarily for rehabilitative purposes and was not "services" for the purposes of trial work.

In arriving at its decision, the Appeals Council noted that the Transitional Employment Program at Prospect House was part of a comprehensive program of rehabilitation services, the primary purpose of which is not to provide training and skills for specific jobs, but to develop and strengthen basic work habits, motivation, attitude and behaviors necessary to any job. While noting that the claimant received wages for his activity the Appeals Council stressed that the claimant was not working at full-time competitive employment, nor was he subject to the normal rules of employer-employee relationships. The total involvement of the Prospect House staff in the placement, training and supervision on-site as well as continued supportive services off-site substantiated the claim that this was a prevocational program.

While the decision of the Appeals Council in this case is not officially binding on any other components of the Social Security Administration, a written decision of the Appeals Council holding that transitional employment programs are not "services" for the purposes of trial work is now available.

Chairman PICKLE. Mr. Shannon?

Mr. SHANNON. I just want to thank all of you for your testimony, which I think was excellent. One of the things that I think each of you touched on is something I think is worth pointing out again, and that is that from the beginning, when the CDI process began, all of the savings that the administration projected included estimates of savings which resulted not from people who were ineligible getting knocked off the rolls, but from people getting knocked off in the review who were so disabled they would not be able to repeal their process, go through this process and get to the ALJ level, and get restored to the rolls after they had been wrongly knocked off the rolls.

This situation has been exacerbated of course by the fact that we have cutbacks in legal aid money and different types of legal assistance.

So you have lots of people, as you pointed out, who get these notifications and just don't respond to them, and don't appeal their cases. And that probably accounts for a lot of the problem with the mentally impaired.

And I think it is one of the things that we have to really take into account. If everybody who could appeal their cases did appeal their cases, you wouldn't have the kind of savings this administration has been able to squeeze out of this program.

You have reminded us of that, and I want to thank you all for your testimony.

Chairman PICKLE. The Chair would also like to thank you and to express his regret he was not able to be here for all of the testimony. I had to go to another subcommittee and thus had to miss part of your testimony.

I do want to make this observation to you, Dr. Meyerson. I have been informed that you have expressed regret that the SSA has not called in groups to talk about some of these problems, particularly in the mental impairment field.

And you have been asking for a chance to have an input and have a conference with key people, and have not been granted that request.

I would hope that the administration would meet with you and your organizations and would do so at any time you asked. We have a representative of SSA here. I wish you would convey that to them. Do you want a meeting with those people?

Dr. MEYERSON. The point I was making, Mr. Chairman, is that Mr. Simmons stated that they had implemented such meetings and such hearings, that Secretary Heckler had sent out letters to that effect.

That is not the case. That is simply not the case.

Chairman PICKLE. They have not met with you.

Dr. MEYERSON. That is right. We had one meeting a year ago at our insistence, when the problem was identified, and since the pressure has been put on by this committee and the Subcommittee on Aging in the Senate, there have been continual statements of their intent to have such meetings, and to change the regulations on the basis of formal professional consultation.

But those formal consultations to date have not been forthcoming, there have been some informal meetings with staff which seemed to go nowhere in terms of developing actual professional consultations.

Ms. BOGGS. The representatives of some of the organizations that I am representing here have, in fact, physically had meetings. But they are totally dissatisfied with the manner in which the meetings are organized.

Chairman **Pickle**. I have been shown a letter here from Secretary Heckler, in which she was replying to a letter——

Dr. **Meyerson**. We received that yesterday.

Ms. **Koyanagi**. We had asked to meet with Secretary Heckler to discuss these things with her and her assistants. You see in the response, she has ignored our request to meet with us.

Chairman **Pickle**. I will see if we can get a clearer response.

I must say to you we are sympathetic. We didn't see them before their latest announcements either.

Well, I thank you very much for your testimony. We are very glad to have it.

Now, the Chair is going to ask that we have a combined panel now. I understand the next witness needs to catch a plane at about 4, and that is shortly.

So I want to ask Jeannette Fanning to come forward first. Then I am going to ask Mr. Bruce Fried, Joe Manes, and Dan Skoler. That leaves one other person. I am going to ask that person, is Dr. Floyd Davis here? No point in you sitting out there. You come up to the table, too.

Though you are from different organizations, what we want to do today—this has been a long day, we know that. We are going to ask each one of you to make your statement. I hope you can summarize in 5 minutes.

First we will ask the testimony—Ms. Fanning.

STATEMENT OF JEANNETTE L. FANNING, PRESIDENT, NATIONAL ASSOCIATION OF DISABILITY EXAMINERS, ACCOMPANIED BY MARTY MARSHALL, LEGISLATIVE CHAIR

Ms. **Fanning**. Thank you, Mr. Chairman. Thank you for your consideration.

With me is Marty Marshall, the legislative chairperson of the National Association of Disability Examiners.

I am the current President of the National Association of Disability Examiners.

I welcome the opportunity to give our views on the social security disability program. Our membership shares the public's awareness of the problems existing in the implementation of the program, especially as it relates to the continuing disability investigations.

NADE members are probably among the most keenly aware of the need for changes and improvements in the program as they are the people dealing with the beneficiaries rights and needs while trying to follow the programs criteria.

The time has come to make the necessary changes for not only a humane program for the beneficiary, but a consistent adjudicatory climate for the examiner. The adjudication climate has been like a pendulum with the trend in the seventies being to find decisions in favor of the applicant whenever there was doubt.

But since SSA accelerated the reviews of those on the rolls after Public Law 96-265 was implemented, the trend, when in doubt, has been to find in favor of the program. Yet there were no overt quotas provided the States, and the definition of disability had not changed.

It is our opinion that the interpretation and application under which we were required to work of the definition has changed.

The definition of disability must be applied equally to new applicants as well as to those beneficiaries having claims reviewed, regardless of impairment.

NADE agrees with curtailing development in permanent impairment cases, but some of the criteria are not consistent with requirements that a new applicant needs to be given benefits.

They are biased against the new applicant. In my written remarks, I have provided examples, the most outstanding being the concern with the cardiac impaired claimant who, if on the rolls, needs only to have been shown to have had two myocardial infarctions—or heart attacks—in order to be continued benefits, but a new applicant with two heart attacks who has also had intervening bypass surgery may possibly be not disabled.

This is inconsistent. We advocate a change in the listings to assist the new applicant, in other words, a loosening of the criteria.

Even permanent impairment criteria are inconsistent. There are three listings whereby a person with an amputated leg can be allowed benefits. But if already on the rolls, he can only be considered a permanent disability if his original decision was based on one of the listings.

If disabled because of the other two listings, he can only be considered a permanent disability if he is 59 years of age or older.

NADE believes that all of these people have a permanent impairment and should be considered thus. Therefore, we are asking for changes in the permanent impairment in those areas.

NADE supports the use of work groups in the Social Security Administration to evaluate more than just mental impairments and to include experts with frontline experience.

We support expansion of the range of IQ's required for mental retardation allowanced to be changed from the current 50 to 59, to 50 to 69 without requiring an additional impairment.

We support the idea that more credibility to be given to lay evidence, work evaluations, and work records in evaluating mental impairment cases where the person doesn't meet the severity of the listings but where there is a question of vocational relevancy.

NADE believes that workshop evaluations, for mental impairment people who don't meet the severity be mandatory where the State has access. If no access is there in the State for these workshops, then SSA should work with the States in establishing these workshops.

The vocational specialist, not the DDS physician, should be the one to complete the vocational forms, especially in mental impairment cases.

Ms. FANNING. The State agencies should also have the ability that the ALJ has to get the medical assessment or functional worksheet completed by the examining physician, not by the reviewing physician within the State agency. It is the examining physician who understands what the person's residual ability is.

We support establishment of a permanent medical and vocation advisory council to maintain standards and changes. We do not support medical improvement unless it considers improvements in: one, medical vocational technologies the beneficiary may have had, two, error on the face of the original allowance, three, possible return to work or SGA, and four, evidence that the original impairment was not as severe as supposed.

Along these lines, NAD has made two proposals which we submitted back in March to the Social Security Administration. In this we have proposed that beneficiaries aged 55 years and older who have been on the disability rolls for 5 years or longer should be continued unless there is specific evidence of medical improvement.

Our second proposal is that beneficiaries aged 50 years and older who have been on the disability rolls for 10 years or more and who have not demonstrated ability to perform past work should be continued. We believe this takes into consideration the adverse effect of having been on the disability rolls plays in a person's successful return to work.

Although NADE believes no one group of beneficiaries should be exempted from review, if a moratorium were put into place for mental impairment cases, we would support the enforcement of time frames for social security to prepare and implement new criteria for review.

For those of us who have been in the program long enough, we realize that back in the mid-1970's when SSI was implemented there was a moratorium put on CDI's. That is why no cases were reviewed for several years. That would impart the importance of timeframes.

Current procedures for establishing disability policy at the various levels are often inadequate and inconsistent because at the State and ALJ levels, the climate can be swayed by quality reviews and returns of claims.

There are guidelines provided examiners in attempts to clarify, such as in the form of the program operations manual, program policy statements transmittal changes, regional program circulars, informational digest changes and teletypes. These eventually work their way into policy by which claims are evaluated but have not been subjected to the rulemaking procedures contained in title V of the U.S. Code. Therefore, they are not binding at all tiers—levels of review.

The ALJ is often seen as the corrector of State errors, but he actually makes a new decision due to availability of evidence, attorney cooperation, the ability to evaluate for pain and the obtaining of residual functional assessments from the examining physician. If these types of tools and latitude were provided the States, there would be fewer reversals necessary.

Although NADE supports the intent of the new evidentiary hearings process mandated by Public Law 97-455, we are concerned that these will eventually adversely affect the goal of national uniformity in case adjudication and further deplete the credibility of State agency decisions, unless some safeguards are effectuated to insure that the hearings officers apply the same criteria as either the States or as the ALJ.

Earlier today it was stated that the Federal people will have a more professional approach for better decisions. But it is anticipated by the personnel department that they will be hiring one-half of their hearings officers from the States. This also will not assist the

States in maintaining ability since the majority of their more professional and more knowledgeable people will be taken.

However, the same process of evidentiary hearings could have been effectuated in the States, avoiding the third review level which complicates the decision process. We do agree that evidentiary hearings at the reconsideration level will shorten the appeals process and reverse decisions at an earlier point than the ALJ's.

NADE supports continued payment of benefits as it has helped beneficiaries in preparing for changes in payment status, should it occur. It has also decreased threats to disability examiners. Payment should be made to the first hearing level so as to avoid overpayment and further hardship to the beneficiary.

As to the issue of acquiescence: nonacquiescence appears to be the only plausible stance currently, since court decisions can vary across districts and no national program should be governed by regional decisions. To acquiesce would not promote uniformity. Even now the Ninth District is reviewing cases under different criteria than the rest of the country.

To this end, we still support a social security disability court which would solve the problem of acquiescence, and eliminate congestion and appeals in the Federal court. More importantly, it would create a single policy body for decisions binding at all levels and enforcing uniformity.

In summary, NADE has made its recommendations, as noted above, to assist examiners by underlining the need for uniformity and consistency throughout the process. We hope consideration will be given to our proposals for changing some of the problem areas to make the disability program a sound and equitable program for the disabled.

Thank you.

Chairman PICKLE. Thank you.

Tell me, is the SSA meeting with your group in these work programs?

Ms. FANNING. Not specifically. I have had one meeting with some people in social security.

Chairman PICKLE. Have you asked for a meeting and not received it?

Ms. FANNING. Yes.

Chairman PICKLE. Are you asking for a new definition of disability or asking for a modified listing of impairments?

Ms. FANNING. For a modified listing of impairments.

For instance, the current permanent impairment criteria for cardiac cases falls under the way that the old medical listings for cardiac cases provided for evaluation.

Chairman PICKLE. You made a large list of recommendations, and I appreciate that you would do it. I personally have had high respect for the NADE organization. I find that you have a very difficult role to perform, and people I have talked with have impressed me that they do it well.

I am impressed with your recommendations. You have made a lot of recommendations.

Can you tell me which one of these you think need specific legislation? If not, will you give us a letter with which ones you think should be legislated on?

Ms. FANNING. I don't know if it would require legislation or just administrative changes. But we are especially interested in having the permanent impairment criteria for the amputated limb the same, regardless of the rationale for being on disability, and also those two proposals about continuation of benefits for the older disabled person.

Chairman PICKLE. What is your feeling with respect to face-to-face hearings for the claimant at the initial level?

Ms. FANNING. We had originally made a proposal to the Office of Hearings and Appeals suggesting that if it was shown that the evidentiary hearings in the pilot studies were successful, that they be brought down to all levels of adjudication. So we would be in favor of that.

Chairman PICKLE. Initial or recondition?

Ms. FANNING. Either way.

Chairman PICKLE. How much leadtime needs to be done?

Ms. FANNING. I think it would take anywhere from 6 months to 1 year to be operative in the States.

Chairman PICKLE. Two commissioners indicated the same leadtime this morning, 6 months to 1 year.

Do you think the State agencies should hold the hearings at the reconsideration level?

Ms. FANNING. Yes.

Chairman PICKLE. Should the State agency do it or should that be Federal?

Ms. FANNING. I mentioned here that we would support the States doing it simply because, as it stands now, it will be a separate adjudicatory function creating a third level. If done in the States, it would add stability and substantiation to State decisions.

Chairman PICKLE. We have your statement. Have you got any specific recommendations in those areas that you think require legislation? Would you follow through and make any suggestions you have?

Ms. FANNING. OK.

Chairman PICKLE. I am going to allow you to excuse yourself, but if you want to make an additional statement, or if any of the panelists want to ask any question of you, we will recognize them for that purpose.

Thank you. If you want to stay for the rest of the panel, we would be pleased if you do so.

Ms. FANNING. Ms. Marshall will be able to handle any questions in my absence.

Thank you very much.

Chairman PICKLE. Again, we are sorry that we had to extend these hearings this long, but that is the way it is.

[The prepared statement and attachments follow:]

STATEMENT OF JEANNETTE L. FANNING, PRESIDENT, NATIONAL ASSOCIATION OF DISABILITY EXAMINERS

Mr. Chairman and Members of the Committee. On behalf of the National Association of Disability Examiners I welcome the opportunity to offer our views on the Social Security Disability Insurance Program. I am the current president of NADE, which has a membership of approximately 1750 persons engaged in a wide variety of functions within the Disability Program. Our membership shares the public's awareness of the problems existing in the implementation of the Social Security Administration's Disability Insurance and Supplemental Security Income Programs; especially as it relates to the Continuing Disability Investigations (CDIs). NADE members are probably among the most keenly aware of the need for changes and improvements in CDIs and the Program. They are, for the most part, examiners; those dealing with the public's concern, the individual beneficiary/claimant's rights and needs, and the criteria of the Program. Since the inception of the Periodic Review of CDIs, the balancing of these three factors of the examiner's workload has not always been easy. The added emphasis on processing time and quality goals, while handling increased caseload sizes, has often strained the abilities of the most experienced examiner. Yet, based on evaluations by the Social Security Administration, accuracy is in the high 90 percent range. This would indicate that in spite of the difficulties in the current review process, the examiner is succeeding in the complex task of providing an honest, compassionate, legal decision as to benefit eligibility. The time has come, though, to make the necessary changes for not only a humane program for the beneficiaries, but a consistent adjudicatory climate for the examiner.

The climate in claims adjudication has been like a pendulum. The trend in the mid 1970s was to find decisions in favor of the applicant (one of the rationales being that heavy caseloads through the introduction of SSI and conversion cases brought pressures to the examining staff and a more loosely interpreted medical criteria). This resulted in some erroneous decisions, but more importantly, the large numbers of cases being reviewed in the periodic process now. The G.A.O. study, the 1980 Amendments (PL 96-265) and the Social Security Administration's action to accelerate the reviews to remove ineligible beneficiaries from the disability rolls once again changed the adjudication climate. Many more recipients than anticipated, were removed from the rolls as decisions were made in favor of the Program. Yet, there were no overt goals established, to my knowledge, to cease a certain percentage of cases. More importantly, the definition of disability under which all the decisions were made "the inability to do any substantial gainful activity by reason of a physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months," has not changed. The interpretation and application of the definition has changed.

If this definition is to be applied equally to those filing new applications and those currently receiving benefits, regardless of impairment, then criteria should also be the same. NADE agrees with the intent of curtailing development in permanent impairment cases. Some of the criteria, though, are not consistent with the requirements a new application must have to meet or equal the severity of the Listing of Impairments. While being advantageous to the beneficiary, the criteria are biased against the new applicant in the mental and cardiac impairment categories, for example. The mentally disabled applicant is required to provide more than one year's continuous treatment, without improvement, in a hospital (the major portion of the permanent definition) before being considered disabled. The cardiac impaired person must, by the current Listings, have evidence of ischemia and chest pain, not just two substantiated myocardial infarctions to be considered disabled. In fact, a person could have had two such MIs, but because of surgical intervention or changes on evaluative devices, as the exercise tolerance test, be considered not disabled. These examples only point out the need to modify the Listings of Impairments for consistency in being placed on the rolls and having benefits continued. With such consistency, there would be a less vague adjudicatory climate for the examiner and a lessened sense of change when the beneficiary is faced with a case review. Similarly, there are inconsistencies in the premanent impairment criteria, such that the person disabled due to an amputated lower extremity meeting Listing 1.10B (due to peripheral vascular disease or diabetes) is considered permanently impaired. However, the person with the amputated limb secondary to 9.08C (due to diabetic necrosis or peripheral vascular diseases) or 4.13C (due to peripheral vascular disease) is only considered permanently disabled if he/she is 59 years of age or older.

NADE supports the use of workgroups, in SSA to assess the changes needed in the Listing of Impairments. We further support the inclusion of front-line examiners in those groups studying the mental impairments. NADE also suggests consideration be given to expanding the I.Q. range required to meet 12.05B (mental retardation) from 50 to 69. Input from medical personnel has indicated that those persons functioning with the intelligence measured in that range do not differ significantly from those in the currently used range of 50 to 59. NADE would also like to see more credibility given to lay evidence, work evaluations and work records in psychiatric impairment cases. As long as reliance in vocational evaluations of these persons is based on the State Agency's physician's review alone, or in conjunction with a single consultative examiner's review, the Program will see little change in the interpretation the applicant/beneficiary can do unskilled work, regardless of policy saying the use sequential evaluation. To further assist in the mental impairment/vocational cases, workshops evaluations should be mandatory, where the State Agency has access to such a facility. Where few or none exist, SSA should actively assist the States in working with the appropriate agencies in establishing them. A recent NADE survey has shown that DDS physicians are often conservative in their role in the case review process, seeing themselves as protectors of the purse and failing to assess the ability to work of the mentally impaired. The vocational specialist in the State Agency should, therefore, assume the responsibility for the completion of the Residual Functional Capacity form, as opposed to the current policy of physician completion. The State Agency should also have the opportunity given the ALJ, to have the Medical Assessment Form completed by the examining physician. Overall, we would again support the establishment of a permanent medical/vocational advisory council to maintain standards and prepare changes.

NADE supports the guides outlined in the Social Security Disability Operational Policy and Procedure Information Digest (No. 79-32 c4.02a; No. 79-33 c4.02b; and No. 79-34 c4.02c) which clarify the issue of assessment of work related abilities in mental impairments. We would go one step further and have these added for mandated use by all review levels, so that sequential evaluation is adhered to, even in mental impairment cases.

NADE does not support medical improvement, unless it takes into consideration improvement in medical or vocational technologies made available to the beneficiary; error on the face of the evidence of the originally allowed determination; return to work (SGA); and evidence indicating the impairment is less severe than originally proposed. In addition, NADE has two proposals which would benefit approximately 15 percent of those on the disability rolls. These are:

1. Beneficiaries, aged 55 years and older, who have been on the disability rolls for five years or longer, should be continued, unless these is specific evidence of medical improvement.
2. Beneficiaries, aged 50 years and older, who have been on the disability rolls for 10 years or more and who have not demonstrated the ability to perform past work, should be continued.

These proposals consider the reliance many disabled persons have come to place on the disabiity benefits they receive, as well as the adverse effect longevity on the rolls plays in a person's successful return to the work force. All of the aforementioned would provide equity in evaluation and less harshness than the present system, but maintain the integrity and purpose of the Disability Insurance Program.

Recent events have resulted in the proposal of a moritorium on mental impairment CDIs. In April, 1983 NADE stated that it could not support the exclusion of any one category of impairments from the CDI process. This was in response to an anticipated halt in the review of mental impairment cases. It is still our position that all cases be reviewed. However, based on the public outcry and the heated debate in legislative and administrative circles a controlled moritorium would be acceptable. It would be acceptable only if the Social Security Administration were held to a specific timeframe for preparing and implementing new criteria for a mental impairments; agreeable to Program managers and the practicing psychiatrist and the American Psychiatric Association and the Diagnostic Statistical Manual.

The current procedures for establishing Federal disability policy at the various adjudicative levels is often inadequate and inconsistent. Steps have been taken to bring the levels in line by issuing Social Security Rulings to the ALJs and incorporating them in the disability examiner's Program Operations Manual (POMS). However, the Rulings only constitute a portion of the POMS and the examiner must apply information from the other sections as well as from Program Policy Statements and non-policy issuances such as the Informational Disgest and regional circulars to their decisions. The ALJ conversely, is not bound by the POMS and also has access to court precedents. At both of these levels of the Program, it is possible for the adjudicatory climate to be further swayed by the returns of quality reviews and assessments. These come from the Disability Analysis Branches to the States and from the Appeals Council to the ALJs. As previously mentioned, guidelines are provided examiners in attempts at clarification, but they often serve to further restrict the criteria in the Listings of Impairments. A recent example would be the POMS transmittal (Number 77, attached) on the consideration of epilepsy which expands the requirements of Listing 11.02 and 11.03. This adds the requirements of an ongoing relationship with a treating source without which the individual's impariment cannot be found to meet or equal the Listings. It also adds the requirement of records of anticonvulsant blood levels before allowance can be made. Other clarifications appear in the Informational Digest and in emergency teletypes, such as the recent ones expanding the curtailed development criteria, when the situation is not covered by the Lisitngs or too recent to have been manualized. Regardless of the origin of such clarifications, they eventually work their way into the policy by which claims are evaluated. They have not, however, been subjected to the rule making procedures contained in section 553 of Title 5 of the Unite States Code. They are not, therefore, binding at all levels. NADE supports more careful issuances of clarifications, they eventually work their way into the policy by which claims are evaluated. They have not, however, been subjected to the rule making procedures contained in section 553 of Title 5 of the United States Code. They are not, therefore, binding at all levels. NADE supports more careful issuances of clarifications, with consistency across the regions, so as to avoid further "policy" changes which resulted in the court case of the Mental Health Association of Minnesota v. Schweiker–No. 4–82-civ. 83. We support the consolidation into the POMS of such guidelines and the release of Program Policy Statements centrally and controlled issuances of regional circulars, as to content.

I have recently been impressed by the similarities of concerns shared by administrative law judges and disability examiners. Concern over the way in which the two positions are required to evaluate cases, with obvious discrepancies. Within recent months, the public has come to view the ALJ as the savior of the Program. His/her relationship to the agency has been perceived as the corrector of the "erroneous" decisions of the State Agency, when in actuality the ALJ is making a de nuvo decision, from that of the examiner, due to additional alleged impairments, worsening of conditions, additional evidence and, in some cases, assistance of attornies in claimant cooperation. The ALJ has more latitude in decisions and has the added benefit of direct contact with the claimant, the use of evaluation of pain and residual functional assessments directly from the examining physician. As NADE has previously stated, it is time that more latitude is provided the examiner while the key role of the ALJ is carried out within the same framework of rules, regulations and policy binding on the examiner (not necessarily the POMS as we now know it). Ongoing medical and vocational training at both levels is also imperative. Both the new applicant and the beneficiary receiving the continuing review deserve better decisions and less of a merry-go-round provided by the dual interpretations of the Program. The Program would receive less criticism if consistency were mandated. Since quality review is necessary, NADE supports the continued review of both levels, but through one reviewing office (this would only be possible if the same criteria were applied at both levels when making the descisions).

The Social Security Administration has now added a third level of review, the evidentiary hearing to this already discrepant system. Even though mandated by PL 97–455, we are concerned that these hearings will adversely affect the goal of nationwide uniformity in decision-making, with a third level of adjudicatory standards, policies and procedures, unless some safeequards are created. The pilot studies for the hearings have shown reversal rates of State Agency decisions ranging from 20 to 30 percent showing what flexibility in decision-making can accomplish. We are concerned that the evidentiary hearings will add yet another interpretation and application of disability criteria and further deplete the credibility of the State Agency's decisions. One way in which to ascertain if discrepancies are present in interpretation at the various levels would be to close the record at the reconsideration level. Reversals would then be more reflective of error, rather than of additions or changes in the claims folder. It would decrease the need for the new step in the appeals process. NADE, along with many State Agency administrators, has recommended that the reviewing offices for the State and the evidentiary Hearings Officers be the same and that:

1. Federal review by the Disability Analysis Branch (DAB) be conducted prior to scheduled evidentiary hearings and after the hearings.
2. Each reversal be returned to the State, providing an explanation and rationale for such reversal since these returns are critical to improving the State operation and assuring uniformity.
3. States be allowed to apply the same adjudicative concepts as are being applied by the Hearings Officers. This could include giving States the same degree of latitude the Hearings Officers are permitted.
4. If experience shows that face-to-face improves the decision-making process, that it be extended to all reconsideration cases.
5. Evidentiary hearing statistics be maintained and published by reason for reversal (e.g., worsening, new evidence, DDS error, impact of face-to-face, etc.).

NADE supports the intent of these hearings functions, to shorten the appeals process by reversing many decisions at an earlier point in time than at the ALJ level. This should assist in keeping down backlogs in ALJ scheduling also. NADE supports the continued payment of benefits through the appeals process, established by P.L. 97-455 because it provides the disabled person with funds while he/she adjusts to the possibility of changes in benefit status. Continuation of payment has also assisted the examiner by decreasing the difficulties with due process and in removing some of the job stress resulting from threats by beneficiaries to either themselves or the examiner. Payment also provides the same benefit to the Title II person as to the SSI recipient, who has been entitled to payment and a face-to-face termination, if that is the final outcome. We believe payment should be made to the first hearing level, to avoid possible overpayments and further hardships to the beneficiary.

The Social Security Administration's current policy of non-acquiescence in District and Appeals Court decisions would appear to be the only plausible stance under current operating procedures. Court decisions can vary from District to District and it would not be reasonable for a national disability program to be governed by such regional decisions. As we noted in our June 8 testimony to the Senate Government Oversight Committee, to require the Secretary to acquiesce or appeal individual court decisions would not promote uniformity in the decision-making process. If acquiescence is followed then even more appeals will result with the actual day-to-day functioning of the Program being quagmired as case processing proceeded on an erratic basis awaiting the settlement of injunctions, stays and decisions. NADE has long supported the establishment of a Social Security Disability Court. This would solve the problem of acquiescence and would lessen the congestion in appeals in the federal courts. More importantly, it would create a single policy body for decisions, binding at all levels, and enforcing uniformity.

SUMMARY

Disability examiners have had the opportunity in recent months to experience the changes being brought about by advocacy work in the area of mental impairments as related to CDIs. They have had first hand experience dealing with the beneficiaries, the media and the administration of the Program. They have continued working with the changes resulting from the 1980 Amendments, even at an accelerated pace. They will continue their efforts for high quality and timely decisions while the new reforms are put into place. The professional disability examiner accepts these challenges the changes bring to the Program. NADE has made its recommendations to assist the examiners by underlining the need for uniformity and consistency, throughout the process. We hope consideration will be given to our proposals for changing some of the problem areas. Much has been stated lately of the humane nature of the reforms. We applaud this attitude on the part of the Administration. NADE also believes that both the new applicant and the current beneficiary deserve humane treatment. They also deserve an explanation of the disability process and how it affects them. Without this knowledge and an awareness that the Program can be modified, there will be no public acceptance. We support whatever efforts are necessary to make the Disability Insurance Program a sound and equitable program for the disabled.

Arterial pCO_2 (mm Hg) AND	Arterial pO_2 equal to or less than (mm Hg)
30 or below	65
31	64
32	63
33	62
34	61
35	60
36	59
37	58
38	57
39	55
40 or above	55

TABLE I — MEN

Height (inches)	Weight (pounds)
60	246
61	252
62	258
63	264
64	270
65	276
66	284
67	294
68	302
69	310
70	318
71	328
72	336
73	346
74	356
75	364
76	374

TABLE II — WOMEN

Height (inches)	Weight (pounds)
56	208
57	212
58	218
59	224
60	230
61	236
62	242
63	250
64	258
65	266
66	274
67	282
68	290
69	298
70	306
71	314
72	322

11.00 Neurological

A. Convulsive Disorders. In convulsive disorders, regardless of etiology, severity will be determined according to type, frequency, duration, and sequelae of seizures. At least one detailed description of a typical seizure is required. Such description includes the presence or absence of aura, tongue bites, sphincter control, injuries associated with the attack, and postictal phenomena. The reporting physician should indicate the extent to which description of seizures reflects his own observations and the source of ancillary information. Testimony of persons other than the claimant is essential for description of type and frequency of seizures if professional observation is not available.

Documentation of epilepsy should include at least one electroencephalogram (EEG).

Under 11.02 and 11.03, a severe impairment is considered present only if it persists despite the fact that the individual is following prescribed anticonvulsive treatment. Adherence to prescribed anticonvulsant therapy can ordinarily be determined from objective clinical findings in the report of the physician currently providing treatment for epilepsy. Determination of blood levels of phenytoin sodium or other anticonvulsive drugs may serve to indicate whether the prescribed medication is being taken. Should serum drug levels appear therapeutically inadequate, consideration should be given as to whether this is caused by individual idiosyncrasy in absorption or metabolism of the drug. Where adequate seizure control is obtained only with unusually large doses, the possibility of impairment resulting from the side effects of this medication must also be assessed. Where documentation

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shows that use of alcohol or drugs affects adherence to prescribed therapy or may play a part in the precipitation of seizures, this must also be considered in the overall assessment of impairment severity.

B. *Brain tumors.* The diagnosis of malignant brain tumor should be established under the criteria described in 13.00B for neoplastic disease. In histologically malignant tumors, the pathological diagnosis alone will be the decisive criterion for severity and expected duration (11.05A). In cases of benign tumors (11.05B) the severity and duration of the impairment will be determined on the bases of the symptoms, signs, and pertinent laboratory findings.

C. ***Persistent disorganization of motor function*** in the form of paresis or paralysis, tremor or other involuntary movements, ataxia and sensory disturbances (any or all of which may be due to cerebral, cerebellar, brain stem, spinal cord, or peripheral nerve dysfunction) which occur singly or in various combinations, frequently provides the sole or partial basis for decision in cases of neurological impairment. The assessment of impairment depends on the degree of interference with locomotion and/or interference with the use of fingers, hands and arms.

D. ***In conditions which are episodic in character,*** such as multiple sclerosis or myasthenia gravis, consideration should be given to frequency and duration of exacerbations, length of remissions, and permanent residuals.

11.01 Category of Impairments, Neurological

11.02 ***Epilepsy—major motor seizures,*** (grand mal or psychomotor), documented by EEG and by detailed description of a typical seizure pattern, including all associated phenomena; occurring more frequently than once a month, in spite of at least 3 months of prescribed treatment. With:

A. Diurnal episodes (loss of consciousness and convulsive seizures); OR

B. Nocturnal episodes manifesting residuals which interfere significantly with activity during the day.

11.03 ***Epilepsy—minor motor seizures,*** (petit mal, psychomotor, or focal), documented by EEG and by detailed description of a typical seizure pattern, including all associated phenomena; occurring more frequently than once weekly in spite of at least 3 months of prescribed treatment. With alteration of awareness or loss of consciousness and transient postictal manifestations of unconventional behavior or significant interference with activity during the day.

11.04 ***Central nervous system vascular accident.*** With one of the following more than 3 months post-vascular accident:

A. Sensory or motor aphasia resulting in ineffective speech or communication; OR
B. Significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C).

11.05 ***Brain tumors.***

A. Malignant gliomas (astrocytoma—grades III and IV, glioblastoma multiforme), medulloblastoma, ependymoblastoma, or primary sarcoma; OR

B. Astrocytoma (grades I and II), meningioma, pituitary tumors, oligodendroglioma, ependymoma, clivus chordoma, and benign tumors. Evaluate under 11.02, 11.03, 11.04A or B, or 12.02.

11.06 ***Parkinsonian syndrome*** with the following signs: Significant rigidity, bradykinesia, or tremor in two extremities, which, singly or in combination, result in sustained disturbance of gross and dexterous movements, or gait and station.

11.07 ***Cerebral palsy.*** With:

A. IQ of 69 or less; OR

B. Abnormal behavior patterns, such as destructiveness or emotional instability; OR

C. Significant interference in communication due to speech, hearing, or visual defect; OR

D. Disorganization of motor function as described in 11.04B.

11.08 ***Spinal cord or nerve root lesions, due to any cause.*** With disorganization of motor function as described in 11.04B.

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T2230. Evaluation of Epilepsy

A. General

Modern treatment has been developed which results in good control of seizures for the majority of epileptics. Consequently, only a small minority of such individuals are precluded from engaging in substantial gainful activity (SGA) because their conditions cannot be controlled by appropriate treatment. It has also been conclusively demonstrated that the majority of treatment failures are due to the individual's noncompliance with the prescribed treatment. Noncompliance is usually manifested by failure to continue ongoing medical care and to take medication at the prescribed dosage and frequency. In a substantial number of cases, use of alcohol has been found to be a contributory basis for the individual's failure to properly follow prescribed treatment. In such cases, the individual's alcohol abuse should be evaluated. (See DI 2155ff.)

B. Evidence of Seizures Occurring Despite Treatment

When seizures are alleged to be occurring at a disabling frequency, the following is essential to a sound determination:

1. An ongoing relationship with a treatment source is necessary. "Treatment source" is a licensed physician, irrespective of specialty. To achieve good control of epilepsy, there must be close rapport between doctor and patient so that the doctor can "tailor" anticonvulsant drugs to the patient's needs. There must be a constant treating source to whom the patient turns for advice and treatment, especially when seizure control wavers. It is not necessary that the claimant see the same physician on each visit, e.g., regular visits to an outpatient clinic would be considered an "ongoing relationship." Also, evaluation must be made in light of treatment prescribed by the treating source, irrespective of whether that treatment is necessarily optimal.

   For epilepsy to be accurately evaluated for disability program purposes, the individual's file must contain adequate information regarding the history of the treatment regimen and his or her response to it. If an individual does not have an ongoing treatment relationship, it would be unreasonable to assume that the seizures cannot be controlled with medication, at least to the level at which the listing would not be met or equaled. Therefore, in the absence of an ongoing treatment relationship, the individual's impairment cannot be found to meet or equal the listings for epilepsy. If the listings are not met or equaled, the particular findings in the case must be evaluated to determine the impairment severity and the expected residual functional capacity (RFC). In such cases, if the evaluation of the medical impairment findings in conjunction with consideration of the vocational

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factors would lead to a determination that the individual is disabled, it is necessary to consider the issue of failure to follow prescribed therapy.

2. There must be a satisfactory description by the treating physician of the treatment regimen and response, in addition to corroboration of the nature and frequency of seizures, to permit an informed judgment on impairment severity. (A purchased examination cannot provide authoritative description of these findings.)

3. In every instance the record of anticonvulsant blood levels is required before a claim can be allowed.

T2230.1 Development Required When There is an Ongoing Treatment Relationship and the Treating Source Indicates that Frequent Seizures are Occurring

When the treating source indicates that frequent seizures are occurring (or continuing to occur) despite anticonvulsant therapy, detailed information is necessary to establish whether the seizures are due to factors beyond the individual's control or to noncompliance with prescribed therapy. If the required information is not included in the initial report, it may be necessary to recontact the treating medical source for information on the treatment regimen and the claimant's compliance with it (e.g., whether there have been missed appointments, alcohol abuse, etc.). If satisfactory information on blood drug levels is not available in the treating physician's records, it must be obtained through a purchased examination.

T2230.2 Evaluation of Low Anticonvulsant Blood Levels

The predominant reason for low (or zero) anticonvulsant blood levels is that the individual is not taking the drugs as prescribed. In extremely rare cases, individual idiosyncrasy in absorption or metabolism of the drug causes therapeutically inadequate anticonvulsant blood levels. The reasons for abnormal absorption or metabolism of these drugs is linked to the individual's clinical condition and would have to be recognized by the treating physician in his or her efforts to obtain control of the seizures. Therefore, a finding that low anticonvulsant blood levels are caused by idiosyncrasy in absorption or metabolism must be based on specific descriptive evidence provided by the treating physician.

When reported blood drug levels are low, therefore, the information obtained from the treating physician should include an explanation as to why the levels are low and the results of any relevant diagnostic studies concerning the blood levels. Unless convincing evidence is provided that subtherapeutic blood drug levels are due to abnormal absorption or metabolism, and the prescribed drug dosage is not itself inadequate for Social Security disability evaluation purposes, the conclusion should follow that the individual is not complying with the treatment regimen. Similarly, in cases in which there is convincing evidence of intermittent noncompliance, including seizure activity because of alcohol abuse, little weight should be given to sporadically obtained anticonvulsant blood levels, even if they are in the therapeutic range. In all cases, however, blood drug levels should be evaluated in conjunction with all the other evidence to determine the extent of compliance with the prescribed treatment.

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T2230.3 Listing Requirements

As set forth in the Listing of Impairments (section 11.00A) epilepsy is evaluated according to the type, frequency, duration and sequelae of seizures. Documentation must include at least one electroencephalogram, and at least one detailed description of a typical seizure pattern, including all associated phenomena. Due to the nature of the impairment, a complete description of a seizure cannot be obtained from the claimant. Therefore, if professional observation is not available, it is essential that a description be obtained from a third party (i.e., family, neighbors, etc.). However, before such contact is made, the claimant's permission must be obtained.

To meet the listing criteria, major motor seizures must be occurring more frequently than once a month (Listing 11.02), or minor motor seizures must occur more frequently than once weekly (Listing 11.03), in spite of at least 3 months of prescribed treatment. Adequate documentation as to cooperation with prescribed treatment is vital to the assessment of impairment severity of seizure disorders. The evidence must reflect the current treatment regimen and information about any recent changes in drug dosage. An allowance is warranted only when the individual is following a treatment regimen prescribed by his or her treating source and continues to have seizures at the specified frequency.

T2230.4 The Impairment Does Not Meet or Equal the Listing

If the individual is following prescribed treatment and the listing is not met or equaled, the sequential evaluation process requires an assessment of RFC. If the claimant is unable to do past relevant work, his or her age, education, training, and work experience, as they relate to the ability to perform any other work, must be considered.

As previously explained, if functional limitations are imposed by seizures but there is no ongoing treatment relationship, the impairment cannot be found to meet or equal the listings. In such cases, the impairment severity and expected RFC must be considered in conjunction with vocational factors. If the individual is found to be disabled, the issue of failure to follow prescribed treatment must be addressed. (See DI 2207-2208.)

It should be noted that there does not have to be an "ongoing treatment relationship" for there to have been "prescribed treatment." In the vast majority of cases where epilepsy has been diagnosed, treatment including drugs has been prescribed.

Evaluation of Prisoner Cases: Title II

T2360. Basic Provisions

The law (P.L. 96-473) provides that title II benefits and determinations of disability for prisoners and persons convicted of felonies will be restricted

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TIMONIUM, MD., *July 4, 1983.*

J. J. PICKLE,
Chairman, Social Security Subcommittee, House Ways and Means, U.S. House of Representatives, Washington, D.C.

DEAR MR. PICKLE: I was pleased to be able to appear before your committee on behalf of NADE, in the recent reviews of the Disability Program. Per your request at that time, I am providing those items we believe require legislation for changes in the Social Security Disability Program. As I noted though, we are proposing changes, included in my written testimony, which would enhance the Program, but might be better effectuated through administrative changes.

We believe legislation is needed to institute a Disability Court which would lessen a backlog in the ALJ reviews and eliminate the need for non-acquiescence and the ensuing debates. We would also support the establishment of a permanent advisory council for medical and vocational standards and training. NADE also supports legislating a time limit for SSA to implement mental impairment listings (6 months from the bill's implementation date), otherwise it may not be a timely change. We believe the definition of disability should remain the same, after all, this really is not like any other entitlement program and disability should be one-hundred percent. We would like to see SSA held to the same criteria for getting on the rolls as are applied to the determination of permanency when reviewing CDIs. I have made note of examples of inconsistency in my testimony. Even if this would be considered an administrative change, perhaps legislatively there could be a push in the proper direction.

NADE supports the need for legislation to continue payment of benefits through the first level of appeals (should the committee opt to pay through the ALJ level, we would still support the need for continued benefits). NADE would like to see the percentages of denied and allowed cases be more equitable, although we could not possibly recommend a specific figure to be reviewed (as noted also by other witnesses). If the use of vocational workshops could not be legislated, then we would hope there would at least be mention of influence in getting SSA to comply with their use and to encourage them to assist the states in establishing them. Unlike many other witnesses and often SSA, itself, we believe the most knowledgeable person involved in claims adjudication is the disability examiner, not the SSA employee. Therefore, we would like to see more concern being given to keeping the State Agency decision a creditable one, and not crating a third level of review in the evidentiary hearings process. We realize the deadline is closing in on the effectuation of the hearings, but it seems no consideration was given to providing the States with the program, but that it was decided before bringing in administrators to tell them how the program would be run.

Although the hearings officers positions created by this new level will mean salary increases for those examiners successful enough in obtaining one of the positions, it will also mean a raiding of many States to obtain well-trained individuals. We would direct your attention to the implications on staffing of the States and resultant problems in handling cases there as well as those concerns we noted in the testimony and which have been directed to the Office of Hearings and Appeals. Should it be decided to go with the new level, as is, then legislation is needed to be certain that that level is treated exactly as the States NADE's thoughts on showing improvement have been provided, and are what we believe should be in legislation. (See attached letter answering our concerns).

I hope this provides you with the concerns you are interested in seeing. Should time permit, I would be happy to comment on any legislation being prepared.

Thank you for your kind words regarding NADE. As usual, it has been a pleasure preparing testimony for your committee and in working with your staff.

Sincerely yours,

JEANNETTE L. FANNING, *President.*

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., June 23, 1983.

JEANNETTE L. FANNING,
President, National Association of Disability Examiners, 5 Hillbrook Court, No. 301, Timonium, Maryland 21093

DEAR MS. FANNING: This is in response to your letter of May 2 regarding the recommendations for the new face-to-face reconsideration procedure which were adopted by the Executive Committee on the Council of State Administrators of Vocational Rehabilitiation (CSAVR).

I appreciate you continued interest in the new reconsideration procedure. As you may know, the CSAVR Executive Committee did in fact adopt the series of five recommendations developed by the DDS Subcommittee. A copy of my letter to Peter Griswold, President of CSAVR, which responds to each of these recommendations in detail, is enclosed.

Let me assure you that, regardless of the difficulty of the task, our goal from the beginning has been to develop a hearing process that meets all reasonable standards of fairness without departing from the principle of consistency of adjudication at all levels. Even though some differences in outcome can naturally be expected to result from a face-to-face procedure as compared with a paper review, this does not require a difference in standards between hearing officers and the DDSs. Thus, we will have review process for hearing officer decisions comparable to that now conducted with respect to DDS reconsidered determinations, using similar procedures and the same adjudicative standards. I am confident, therefore, that new level of adjudicative standards will not evolve as a result of the availability of the face-to-face reconsideration hearing.

We expect that a notice of proposed rulemaking for the new reconsideration procedure will be published in the Federal Register within in a few weeks. I have asked my staff to send you a copy to be sure that the members of NADE have an opportunity to review and comment on the regulations.

Thank you again for your comments and suggestions.

Sincerely yours,

LOUIS B. HAYS,
Associate Commissioner, Office of Hearings and Appeals.

Enclosure.

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., June 23, 1983,

PETER P. GRISWOLD,
President, Council of State Administrators of Vocational Rehabilitation, 1055 Thomas Jefferson Street, NW., Washington, D.C.

DEAR MR. GRISWOLD: This is in response to your letter of April 26 to the Commissioner, regarding the face-to-face hearing at the reconsideration level in disability termination cases. Please accept my apology for the delay in responding.

I appreciate the interest of the Executive Committee of the CSAVR in formulating the list of five recommendations for modifying the pilot project we recently completed to test the new reconsideration procedure. Since the pilot project has now ended, I am taking the liberty of addressing your comments in the context of the natiowide process to be implemented beginning in October.

Your first recommendation is that the review by the Disability Analysis Branches (DABs) be conducted immediately after the State Disability Determination Service (DDS) agency completes its preparation of the case for the reconsideration hearing. This change, of course, would only apply to those cases in which the DDS had not issued a favorable reconsidered determination, since favorably reconsidered cases proceed directly from the DDSs to the DABs and are not involved in the actual hearing process. Although I can apprecite the desire of DDS personnel to get a "clean bill of health" from the DABs before cases are forwarded to the federal disability hearing units, I do not believe it will be feasible to interject this review at the mid-point of the reconsideration process without sacrificing the timeliness that I believe Congress and the public expect from the new process. To the extent this recommendation is based on concerns that the DABs will treat hearing officer decisions differently than DDS decisions, I can assure you that this will not occur.

The second recommendation adopted by the Executive Committee is that copies of favorable hearing officer decisions be provided to the originating DDSs. These decisions include a rational for the hearing officer's determination. I can appreciate the desire of the DDSs for this type of feedback and agree that to the extent practical it should be provided. Even if it is not feasible to provide a copy of every decision, I would think that a combination of a sample of decisions plus a compilation of data (discussed below) would serve the same purpose.

I believe that your third recommendation may be based on some misunderstanding as to the "latitude" given the hearing officers. We have from the start believed that hearing officers should be held to the same standards of adjudication and accountability as the DDSs. This is in keeping with SSA's emphasis on improving adjudicative consistency among all levels of the disability decisionmaking process. Of course, the decisionmaker who meets face-to-face with the beneficiary has the opportunity to elicit additional information which was not available to his or her counterpart in the DDS. However, the standards by which cases are decided are the same. Therefore, I believe your recommendation that the DDSs "be allowed to apply the same adjudicative concepts" as the hearing officers has already been adopted as an essential part of the process.

Your fourth recommendation is that the new face-to-face reconsideration procedure be made available in all disability cases and "at all decisional points" if it proves successful in termination cases. As you may know, we originally considered the idea of including all cases in the new face-to-face reconsideration procedure but decided against it because of the specific legislative mandate to provide this procedure in termination cases by January 1, 1984. Although we have naturally concentrated our attention on this immediate goal, I can assure you that as we progress towards full nationwide implementation of the new procedure in termination cases, we will monitor its effectiveness to determine if future expansion to the remainder of the disability caseload at the reconsideration level should be considered. The concept of a face-to-face procedure at the initial level, on the other hand, has enormous logistical and workload implications, and could be considered somewhat duplicative of the initial face-to-face contact in local Social Security field offices.

Finally, I believe we are in agreement that there is a need to compile and make available statistical data regarding reasons for favorable hearing officer decisions. This information will be necessary for management and accountability purposes and will also, I expect, be useful to the DDSs as a feedback device.

In closing, let me assure you that we have attempted from the beginning to be sensitive to the perspective of the DDSs in planning for the face-to-face reconsideration procedure. Towards this end, we formed an advisory group of DDS administrators shortly after the enactment of P.L. 97-455 to participate in the planning process for the new reconsideration procedure. My impression from our meetings with this group is that our shared desire to improve all aspects of the CDI process will result in an improved reconsideration procedure that is satisfactory to all of us charged with its administration, as well as to the beneficiaries it will serve. I appreciate the interest of the CSAVR in this process and look forward to a continuing dialogue in the months ahead.

Sincerely yours,

Louis B. Hays,
Associate Commissioner, Office of Hearings and Appeals.

Chairman Pickle. We will next hear from Mr. Fried, I believe would be next.

Mr. Bruce Fried, staff attorney for the National Senior Citizens Law Center.

STATEMENT OF BRUCE M. FRIED, STAFF ATTORNEY, NATIONAL SENIOR CITIZENS LAW CENTER

Mr. Fried. Thank you, Mr. Chairman.

Chairman Pickle. Before you start, I am going to—I believe it might be convenient if you make your statement, and then we will make the other statements and then we will talk together.

Mr. Fried. I would like to express my appreciation to yourself and to Mr. Shannon for inviting us to appear before you today.

As you know, I am an attorney at the National Senior Citizens Law Center which serves as a central support and technical assistance unit within the legal services community allowing us to serve, through local legal services programs and the 5,000 attorneys and the 1,000 paralegals that are throughout the country, older and disabled low-income people.

Our participation with that system allows us to garner experience and therefore share that world of experience with the committee.

Chairman Pickle. Where are you located?

Mr. Fried. We have offices in the District and in Los Angeles.

Chairman **Pickle**. Have you been before the committee before?

Mr. **Fried**. I have not. You are familiar with my colleague Eileen Sweeney, who expresses her apologies for not being able to be with you today.

The committee has heard several things today that go to the issue of procedures that impact on the disability determination system. I would like to address several of those.

We have submitted a fairly lengthy testimony and I don't see any necessity to review each of the points.

Chairman **Pickle**. The entire statement will be made a part of the record.

Mr. **Fried**. I would like to address the nonacquiescence issue.

As the committee knows, the Social Security Administration is currently pursuing an illegal and arrogant practice, and "arrogant," I should say, is a word that doesn't come from me but comes from a U.S. district court judge in the southern district of California, which last week found that the administration was nonacquiescing with respect to two earlier cases that had been decided by the Ninth Circuit.

It was that judge that said he saw this as arrogant behavior on the part of the administration, arrogant in the sense that the administration has decided that it simply will not follow a decision that it does not agree with nor will it appeal those decisions.

Nonacquiescence occurs in two very important ways. The first is what we call formal nonacquiescence where we see the administration issuing social security rulings in which they say the Secretary holds that the decision in *Patti* v. *Schweiker,* or any of other decision with which they disagree, will not be followed by the administration.

The second is informal nonacquiescence where the administration simply doesn't conform its policies with holdings of the circuit courts nor do they publish the fact that they are not conforming. They are just refusing to comply with court-made law.

Chairman **Pickle**. Let me interrupt. I didn't have a feeling that they were saying that they would not comply with the court decision, the final decision that had been made by the court.

Are you saying that this morning they said no matter what, they were not going to comply with it?

Mr. **Fried**. They will issue a social security ruling in which they will summarize the decision of the court of appeals and then explain why social security policy is contrary to that decision, and then hold that they will not comply with the opinion of the court.

I think that is exactly what they were saying this morning.

Chairman **Pickle**. You mean no matter what the court rules——

Mr. **Fried**. Let me correct any misunderstanding. They do apply the decision to the individual in the particular case. They don't apply it circuitwide.

Chairman **Pickle**. Is that what they do?

Mr. **Fried**. It is shocking.

Chairman **Pickle**. SSA is separate and apart?

Mr. **Fried**. Again I point the committee's attention to the same judge in this *Lopez* case that was recently decided, where the court said that the Secretary is acting outside the bounds of the law. I don't know what could be said more succinctly about the policy.

There was an effort, by the general counsel that was here with Deputy Commissioner Simmons, to point to the IRS's practice of nonacquiescing. Indeed, the IRS does have a procedure whereby they will nonacquiesce.

I should point out to the committee that it is substantially different than the procedure followed by the Social Security Administration.

Attached to my statement is a footnote from testimony that Elena Ackel, an attorney from the Legal Aid Foundation of Los Angeles submitted in earlier hearings, which traces the Service's, the Internal Revenue Service's procedures.

The significant difference is that where the Internal Revenue Service nonacquiesces, it nonacquiesces as to other circuits. It follows the law of the circuit that the circuit court has enunciated but chooses to not follow the law in other circuits.

Instead, they aggressively pursue litigation in those other circuits so that a discrepancy in the circuit laws can be developed, if in fact that happens, and thereby providing an avenue for Supreme Court review.

Chairman **Pickle**. What was the rationale of the SSA folks this morning when they said they would not follow?

Ms. **Dilley**. They said that—I believe SSA said that they didn't want to do that because they didn't want to have a different law in each circuit of the country, that they wanted to keep following their own regulations, only apply to a certain court's decision in an isolated case so they won't have different laws apply to different circuits.

IRS follows a policy of acquiescing in circuit court decisions.

Chairman **Pickle**. I don't want to dwell on that. I can see the reasoning—but when you go to court and a case is settled, not just that case——

Mr. **Fried**. Certainly the people have as much an interest in uniform tax policy as we do in a uniform social security policy.

If the IRS is willing to administer a system whereby they can have different policies in different circuits and yet pursue that policy so that it reaches the Supreme Court or Congress——

Chairman **Pickle**. Go ahead with your testimony.

Mr. **Fried**. Let me move ahead to the question of Social Security Administration compliance with the Administrative Procedure Act.

There was some degree of discussion already today about the use of the so-called social security rulings as a way for the Administration to implement policy. It is an issue that we have grave concern with because we have seen a number of circumstances where social security rulings have been used to implement policy that differs from either Federal regulations, or in a number of instances, from statues themselves.

For a particular instance, I refer the chairman to that portion of my testimony where we discuss the vocational rehabilitation situation. I won't discuss that, but it is a good illustration of the problem we have here.

One of the issues in the 1980 Social Security Amendments that is part of the problem of CDI was the requirement that benefits continue to be paid to SSI recipients who begin a vocational rehabilitation program approved by the Social Security Administration, so long as that program is likely to lead to the individual being permanently removed from the social security rolls.

Benefits can be paid in that instance even if the individual's disability ceases while they are involved in this program—an excellent idea by Congress.

The problem is that in a social security ruling, the Social Security Administration added a new criteria never required by Congress that basically says if the individual is diaried, if the individual is likely to have their disability improve during the time that they are involved in this vocational rehabilitation program, they can't receive the benefit. There is no basis in law for that.

Had that wholly new policy been subjected to the review and comment procedures required by the Administrative Procedure Act, I think we, for one, would have called that to the Administration's attention and I think we could have avoided what now is a series of litigation over this clearly illegal provision.

Chairman **Pickle**. When did they decide to make that change? Is that recent?

Mr. **Fried**. I would call your attention to page 23 of my testimony. It was a 1982 social security ruling, I believe, that appeared in the October 1982 publication of Social Security Rulings.

You will see on page 23 of my testimony, beginning about midway down in the page, we begin that portion of the testimony that addresses this particular issue as a problem in and of itself, but I think it is also valuable to highlight the problem that we have with social security rulings being used to implement new policy.

The point to be made, though, is that were beneficiaries, and the public generally, afforded the opportunity to review SSA proposals, vis-a-vis new policy, and to comment accordingly, much of the problems we have in these sorts of things could be avoided.

I think Mr. Simmons' comments about the fact that this would be burdensome and time consuming is really a strawman. The Social Security Administration has excellent staff. They can promulgate regulations in a timely way.

If it is an urgent situation, there is no reason why interim final regulations can't be used, allowing comments to continue to be made, and then take those into consideration when final regulations are promulgated.

Chairman **Pickle**. Mr. Cohen I think stated that perhaps if you didn't publish all the rulings in regulations and make them official immediately, at least you would publish the rulings and allow all groups to comment.

Mr. **Fried**. I must say I was a bit taken aback by some of what Mr. Cohen seemed to be saying. Not having had an opportunity to talk with him beforehand, I surmise that he was suggesting that the rulings themselves be published in a way that beneficiaries and attorneys have an opportunity to look at them.

Frequently when we get calls from either legal aid lawyers or members of the private bar, and we call their attention to social security rulings, they don't know what they are. They have never seen them before because they are not part of a public record.

For beneficiaries, if attorneys don't know that these things exist, how can we expect beneficiaries to know that there is a place where policy is being articulated that they need to be aware of when applying for benefits. It doesn't make sense in a good public policy sense.

Returning to two issues that relate to the standards that are used in assessing whether an individual continues to be disabled or not, I would like to touch briefly on the question of assessing the severity of impairments. I think that is a topic that the committee hasn't had a chance to hear about today.

In 1982, the Social Security Administration denied or terminated more than 40 percent of adjudicated cases on the basis of nonsevere impairments. There are two reasons why this happened.

The first is that the administration fails to consider vocational factors when it is making an assessment of whether an impairment is severe or not.

The second is that the Social Security Administration refuses to consider combined effects of nonsevere impairments.

When I think about the combined effects situation, I visualize the picture of a side of beef that is going to be carved up for sale at the butcher shop, and it seems to me that social security is in a sense doing that with persons who have a combined impairment. They look at separate parts and don't see that there is a cumulative effect.

There is a holistic approach that needs to be taken when assessing whether a series of impairments, when combined, ultimately end up being severe, though individually they may be nonsevere. In fact, it is our sense that this is exactly what Congress intended, that individuals be looked at for the combined nature of their impairments.

I would point out that section 102 of H.R. 2987 clearly articulates the requirement that a person's impairment is to be looked at in a holistic sense so that the administration can get a clear and whole picture of what that individual's capabilities are.

With respect to the issue of vocational considerations in determining whether an impairment is severe or not, social security has made two claims about why they don't do that. The first is that you, Congress, didn't intend that that be done. The second is that to consider vocational factors would be a burden on the administration, especially when they would have to perform such vocational assessments when the individual has a stubbed toe, that kind of very minor impairment.

As to the first claim, that Congress didn't intend for vocational factors to be considered, that clearly is not supported by the statute. The statute very clearly requires the administration to incorporate both medical and vocational factors in assessing the severity of an individual's impairment.

Not only is that clearly set out in the statute, but a number of courts have found that Congress intended that the vocational factor be also considered. In fact, the Social Security Administration itself has said that vocational evaluation can be applied as efficiently as the nonsevere impairment requirements.

We have to remember with respect to that that the claimant has the burden to show that they can't do past relevant work. Only then does the burden shift to the Social Security Administration.

If it is really a stubbed toe situation, I suggest that an individual couldn't make the necessary representation, they couldn't meet their burden of demonstrating that they couldn't do their past relevant work.

Chairman **Pickle**. Why do you use the phraseology in talking about something as a "stubbed toe situation"?

Mr. **Fried**. It is a phrase that the Social Security Administration itself has used in discussing this issue.

Chairman **Pickle**. Earlier this morning, one representative of the SSA was giving to me some encouragement that they would perhaps on medical improvement—I assume it is a broader field—they were going to start looking, there was a possibility.

They didn't make any commitment, you know. They are going to look at age, and they were going to consider the link, the time, and vocational factors. That was somewhat encouraging to me because they hadn't conceded that much in the past.

I hope we can build on that.

I thank you very much for your testimony. You have given us a long statement and a lot of it is technical in nature. We won't try to go into all of it, but I do appreciate your statement.

[The prepared statement follows:]

STATEMENT OF BRUCE M. FRIED AND EILEEN P. SWEENEY OF THE NATIONAL SENIOR CITIZENS LAW CENTER

SUMMARY

This statement addresses many, but not all, of the problems currently facing disabled applicants and beneficiaries in the Social Security and SSI programs, and endorses H.R. 2987 as a well-developed package, designed to solve these problems.

The following points are made:

I. The standards utilized by SSA in evaluating disability should be changed. (page 2)

A. SSA should be required to continue benefits unless there is evidence of medical improvement or that the original decision was clearly erroneous. (page 3.)

B and C. SSA should be required to consider vocational factors and the combined effect of all impairments in assessing severity of impairment. (page 6.)

D. SSA should be required to consider all evidence of the existence and degree of pain. (page 10.)

II. A number of SSA's procedures must be improved, changed, or otherwise revised to assure that applicants' and recipients' cases are handled expeditiously and fairly. (page 12.)

A. Statutory language should make clear that SSA must follow the public notice and comment requirements of the APA. (page 13.)

B. SSA should be required to follow the decisions of the Circuit Courts of Appeals unless they are overruled by the Supreme Court. (page 16.)

C. SSA should be specifically required by statute to issue regulations governing the use and monitoring of consultative examinations. (page 19.)

D. The face-to-face interview should be conducted at the initial level of review. (page 21.)

III. Miscellaneous concerns. (page 23.)

A. SSA is violating § 301 of P.L. 96-265 [vocational rehabilitation] (page 23.)

B. Steps should be taken to clarify the mechanisms by which private attorneys can obtain their fees in disability cases. (page 25.)

IV. Secretary Heckler's recent proposals do not address the problems faced by most disability beneficiaries subjected to CDI review. (page 26.)

STATEMENT

I am Bruce M. Fried, a staff attorney at the National Senior Citizens Law Center (NSCLC), appearing today for myself and Eileen P. Sweeney, at the written invitation of Representative James Shannon, a member of this Subcommittee. We are most appreciative of the opportunity to appear before the Subcommittee today and to submit written testimony.

NSCLC is a national support center, specializing in the legal problems of elderly poor people. We are funded by the Legal Services Corporation and provide support services to legal services attorneys throughout the country with respect to the legal problems of their elderly and disabled clients. Our responsibilities include working with legal services and aging advocates on the Social Security and Supplemental Security Income problems of their clients.

Our testimony will focus on a number of issues related to the standards utilized by SSA in assessing disability and procedural problems which have arisen. As we are aware that others who will testify will focus specifically on the problems faced by mentally disabled individuals, we have not addressed all of these issues here. It is our intention to avoid repeating testimony which we have previously presented to this Subcommittee.

In reviewing the issues set forth below, three underlying factors should be noted. First, with the exception of the medical improvement standard and the availability of aid pending appeal, the problems for new applicants are identical to those of recipients subjected to the CDIs. Second, our experience indicates that the problems of the physically impaired with the system, particularly those with multiple impairments, cardiac conditions, and back problems are no less severe than those faced by the mentally impaired. Third, the changes recommended are equally applicable to the SSI program where SSA is already terminating significant numbers of non-concurrent beneficiaries as well as concurrent beneficiaries under CDI review.

Finally, we believe that H.R. 2987, introduced by Representative Shannon, represents a well-thought-out package of reforms and improvements in the disability determination process. It represents the considered opinion of organizations representing the disabled and has received the endorsement of a wide range of religious, women's, elderly and labor organizations. We recommend that H.R. 2987 be the basis for reforms made by this Subcommittee and that it be passed in its current form, amended to extend its coverage to the SSI disability program as well.

The need for legislative action in this area has not diminished. Secretary Hecckler's recently-announced proposals emphasize, rather than mitigate, this need.

I. THE STANDARDS UTILIZED BY SSA IN EVALUATING DISABILITY SHOULD BE CHANGED

In our experience, there are essentially five problems in the area of standards which currently are creating the greatest hardships for disabled beneficiaries and applicants:

(A) SSA's insistence on terminating benefits despite the fact that there is no evidence of medical improvement;

(B) SSA's failure to consider vocational factors in assessing whether an impairment is severe;

(C) SSA's refusal in many cases to consider the combined effects of multiple impairments;

(D) SSA's failure to consider the existence of pain and the effect which debilitating pain has upon the ability to perform substantial gainful activity; and

(E) SSA's failure to properly evaluate the impairments and limitations of mentally disabled individuals.

As noted earlier, we will address the first four. The fifth will be addressed by many others testifying today.

A. SSA should be required to continue benefits unless there is evidence of medical improvement or that the original decision was clearly erroneous.

Numerous courts have recently ruled against SSA's current policy and have required SSA to have evidence of medical improvement or that the original decision was clearly erroneous before disability benefits can be terminated.[1] This has been

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[1] See, for example, *Finnegan* and *Mathews,* 64 F.2d 1340 (9th Cir. 1981), *Simpson* v. *Schweiker,* 691 F.2d 966 (11th Cir. 1982); *Musgrove* v. *Schweiker,* 552 F.Supp. 104 (E.D. Pa. 1982);

Continued

the ruling in workers' disability cases as well as in SSI and SSI "grandfathered" cases. Other courts have ruled that once a person has been found to be disabled, there is a presumption that he/she remains disabled and that SSA has the burden of proving that he/she is no longer disabled.[2] SSA has issued "rulings on non-acquiescence" in at least two of these cases, *Patti* and *Finnegan*.[3]

It is worth noting that SSA already applies the "medical improvement" analysis in two contexts. First, SSA applies the "Medical improvement" test in determining that any individual whose impairment is on the list of "permanent disabilities" (and is thus exempt from CDI review) will be reviewed despite the exemption. Second, the notion of "medical improvement" is the basis for SSA's system of "diarying" cases for reviews. If SSA staff believe that an individual's condition is likely to improve, his/her case will be "diaried" for a particular time, at which a review will take place. In other words, SSA utilizes the concept of medical improvement when it is likely not to be beneficial to recipients (in terms of continuation of their benefits), but not when it could assist the recipient to retain eligibility. More importantly, SSA is familiar with the concept and not only knows how to use it, but is currently using it.[4]

The numerous court decisions and SSA's own current use of the medical improvement standard raise serious questions about SSA's alleged need to study the issue further (as proposed by Secretary Heckler) while depriving individuals being subjected to the CDIs of the benefit of the standard.

We believe that the "clear and convincing" evidence standard set forth in § 101 of H.R. 2987 is the appropriate standard of review in these cases. It generally requires that the government assume a higher level of risk than would be required with a "preponderance of the evidence" standard. In the context of assuring accurate decisionmaking where disabled individuals at least once previously have been determined to be disabled by SSA, it is desirable to require that this intermediate level of proof be required. Further, SSA already has familiarity with the "clear and convincing" evidence standard in evaluating the eligibility of an illegitimate child to receive benefits on the account of a deceased wage-earner parent. 42 U.S.C. § 416(h)(2)(A) provides that children who would be entitled to inherit from the wage earner parent under state intestacy laws are deemed to be dependent and eligible to receive benefits. In that context, SSA staff regularly apply many state intestacy laws which have been modeled on the Uniform Probate Code (UPC). The UPC provides for inheritance where there is "clear and convincing" evidence of paternity. In that context, SAA has provided its staff with the following description of the standard:

> Generally, the evidentiary standard of "clear and convincing proof" or "clear and convincing evidence is an intermediate standard, requiring more certainty on the part of the fact finder than a "preponderance of the evidence" standard, but less certainty than the "beyond a reasonable doubt" standard historically reserved for use in a criminal case. POMS § T00306.125, "Evidentiary Standards Under State Intestacy Laws"

B. and C. SSA should be required to consider vocational factors and the combined effect of all impairments in assessing severity of impairment.

In 1982, SSA denied or terminated 40.2 percent of the cases it adjudicated on the basis of a "slight" (read "non-severe") impairment.[5] In 1981, the figure was even higher: 45.2 percent.[6]

These high figures are only possible for two reasons:

(1) SSA fails to consider vocational factors in assessing severity of impairment.

(2) SSA refuses to consider the combined effects of "non-severe" impairments in assessing severity.

Each issue is discussed below.

Singleton v. *Schweiker*, 551 F.Supp. 715 (E.D. Pa. 1982); *Shaw* v. *Schweiker* 536 F.Supp. 79 (E.D. Pa. 1982); *DeValut* v. *Schweiker*, Civ. Action No. 81-0070-C (N.D. W.Va. 1982); *Dudley* v. *Schweiker*, Civ. Action No. 81-0004-C (N.D.W.Va. 1982).

[2] See, for example, *Patti* v. *Schweiker*, 669 F.2d 582 (9th Cir. 1982); *Luke* v. *Schweiker*, CCH Unempl. Ins. Rptr. paragraph 17,993(c) (D. Miss. 1981).

[3] Social Security Rulings 82-10c (*Finnegan*) and 82-49c (*Patti*). The issue of SSA's non-acquiescence policy is discussed, *infra*, at pp. 16-19.

[4] And, before 1976, applied it regularly in all cases.

[5] "Background Material and Data on Major Programs Within the Jurisdiction of the Committee on Ways and Means," Committee on Ways and Means, U.S. House of Representatives, WMCP: 98-2 (February 8, 1983) page 79.

[6] *Id.*

(1) SSA fails to consider vocational factors in assessing severity of impairment.

Under SSA's sequential evaluation, the finding of nonseverity is wholly medical; no consideration is given to the vocational factors (age, education and work experience). See 20 C.F.R. § 404.1520(c). SSA has taken the position that this is as the Congress intended, that there must be a solely medical assessment initially. Further, SSA claims that it would be extremely burdensome for it to have to perform vocational assessments where the person only has a "stubbed toe."

42 U.S.C. § 423(d)(2)(A) provides that a wage earner "shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy . . ." Here, the "severity" standard incorporates both the medical and vocational factors. In the last couple years, there have been many court decisions upholding SSA's determination that the claimant did not have a severe impairment. However, it should be noted that it does not appear the plaintiffs challenged the validity of SSA's "non-severe" step. In *Scruggs* v. *Schweiker*, 559 F.Supp. 100, 103 (M.D. Tenn. 1983), the court held that SSA could not separate out the medical from the vocational:

> Thus, it appears that Congress fully intended that the severity of clinically established impairments be considered in relation to the vocational prospects of the individual. A non-severe finding, with nothing more, does not comply with this statutory requirement.

SSA has itself wholly undermined its "stubbed toe" analysis, effectively eliminating it as a basis for concern. In *Lofton* v. *Schweiker*, 653 F.2d 215, 217–218, n.1 (5th Cir. 1981), the Court refers to SSA's introduction to the 1979 regulations which included the sequential evaluation process:

"... The Secretary observed that:

> 'In most cases that involve an impairment that is not severe, the vocational evaluation guides can be applied as efficiently as can the nonsevere impairment principle. Most cases of this kind do not require extensive investigation of a person's vocational background in order to evaluate them under the vocational guidelines. We can decide many cases of this type on the basis that a person can return to his or her most recent occupation.' The Secretary is currently studying the feasibility of revising this regulation."

Of course, the burden is on the disabled individual to prove that he/she can not perform his/her past relevant work. It is not until after that step that the burden shifts to SSA. As a result, the cost of properly including a vocational assessment is low, while assuring that those entitled to receive full vocational assessments receive them. SSA said "most", not all, would be picked up at the past relevant work stage. The others are entitled by statute to a full vocational assessment.

(2) SSA refuses to consider the combined affects of "non-severe" impairments in assessing severity.

SSA has taken the position that it will not combine the effects of "non-severe" impairments in assessing severity. In Social Security Ruling #82–55, SSA stated:

> Inasmuch as a nonsevere impairment is one which does not significantly limit basic work-related functions, neither will a combination of two or more such impairments significantly restrict the basic work-related functions needed to do most jobs. However, when a nonsevere impairment(s) is imposed upon a severe impairment(s), the combined effect of all impairments must be considered in assessing RFC.

SSA's own regulation is even worse. 20 C.F.R. § 404.1522 provides that SSA "will consider the combined effects of unrelated impairments only if all are severe and expected to last 12 months." [7]

The result of the application of either 20 C.F.R. § 404.1522 or Social Security Ruling #82–55 is that many severely disabled individuals are being denied benefits or having their benefits terminated because SSA fails to acknowledge the existence of some or all of their impairments and fails to consider the impact of these impairments upon their ability to engage in substantial gainful activity.

Section 102 of H.R. 2987 addresses this problem well. It simply requires the Secretary to consider the combined effect of *all* impairments in assessing severity. It does not in anyway modify the disability test set forth in the statute but assures that all disabled individuals will receive full and fair consideration of the effects of all of their impairments.

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[7] While SSR 82–55 can be read as a liberalization of the regulation, the content of SSR 82–55 has been SSA's policy for some time. This presents an excellent example of a situation where SSA should have utilized the public notice and comment procedures of the Administrative Procedure Act. Had it done so, it might have developed a policy very different from the current policy which excludes consideration of numerous impairments.

D. SSA should be required to consider all evidence of the existence and degree of pain.

"Pain" is a concept foreign to SSA. While it is discussed in SSA's regulations, it has been stripped of its meaning and categorized to the point where it no longer exists as a factor to be considered in most, if not all, disability evaluations. For example, in Social Security Ruling 82-55, SSA identified a number of impairments which it has determined to be "non-severe." In doing so, SSA stated that it had presumed a level of pain for each condition:

> "In formulating these examples, the potential for severe and prolonged pain has been considered. These conditions are not expected to produce severe and prolonged pain."

In other words, even if a person suffered from far greater pain, SSA would ignore his/her proof of this fact.

Further, in Social Security Ruling 82-58, SSA limited the consideration of pain further than that set forth in its own regulations. 20 C.F.R. § 404.1529 provides:

> If you have a physical or mental impairment, you may have symptoms (like pain, shortness of breath, weakness or nervousness). We consider all your symptoms, including pain, and the extent to which signs and laboratory findings confirm these symptoms. The effects of all symptoms, including severe and prolonged pain, must be evaluated on the basis of a medically determinable impairment which can be shown to be the cause of the symptom. We will never find that you are disabled based on your symptoms, including pain, unless medical signs or findings show that there is a medical condition that could be reasonably expected to produce those symptoms.

Despite that language, stating that SSA will consider pain if there is evidence of "a medical condition that could be reasonably expected to produce those symptoms," SSA added an extra test in SSR 82-58:

> Symptoms will not have a significant effect on a disability determination or decision unless medical signs or findings show that a medical condition is present that could reasonably be expected to produce the symptoms which are alleged or reported. However, once such a medical condition (e.g., disc disease) is objectively established, the symptoms are still not controlling for purposes of evaluating disability. Clincial and laboratory data and a well-documented medical history must establish findings which may reasonably account for the symptom in a particular impairment. Objective clinical findings which can be used to draw reasonable conclusions about the validity of the intensity and persistence of symptoms and about its effect on the individual's work capacity must be present. For example, in cases of back pain associated with disc disease, typical associated findings are muscle spasm, sensory loss, motor loss and atrophy. There must be an objective basis to support the overall evaluation of impairment severity. It is not sufficient to merely establish a diagnosis or a source for the symptom.

In our testimony before this Subcommittee in October 1981, we discussed in detail a number of examples of cases where a restrictive definition of pain would result in seriously disabled individuals being denied benefits.[8] SSA has essentially adopted that extremely restrictive approach in its ruling.[9]

Section 103 of H.R. 2987 is well-designated to assure that all evidence of pain is fully considered, including subjective evidence of pain. We believe that it will assure that disabled applicants and recipients like those discussed in our 1981 testimony will receive a full evaluation of their problems early in the process and will not be required to resort to district and circuit court reveiw in order to establish their eligibility.

II. A NUMBER OF SSA'S PROCEDURES MUST BE IMPROVED, CHANGED OR OTHERWISE REVISED TO ASSURE THAT APPLICANTS' AND RECIPIENTS CASES ARE HANDLED EXPEDITIOUSLY AND FAIRLY

There are a number of procedural problems which this Subcommittee should address. These include:

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[8] "Social Security Appeals and Case Review Process," Hearings before the Subcommittee on Social Security of the Committee on Ways and Means, Serial 97-31, pp. 203-205.

[9] Again, without the benefit of public notice and comment.

A. SSA's failure (and refusal) to follow the Administrative Procedure Act (APA) in issuing new policy and changes in policy;

B. SSA's refusal to follow circuit courts of appeals decisions, instead "non-acquiescing;"

C. SSA has not issued regulations for the states to utilized in making consultative examination referrals or monitoring the process.

Finally, we discuss briefly in (D) our concerns with the face-to-face interview at the reconsideration level of review.

A. Statutory language should make clear that SSA must follow the public notice and comment requirements of the APA

Despite the fact that SSA, as with all of HHS, has been under the Administrative Procedure Act since 1970 by order of then-Secretary of Health, Education and Welfare Elliot Richardson, SSA persists in ignoring its obligations pursuant to the APA. In particular, SSA issues new policy directives at low levels of the agency without first having published the changes in the Federal Register and obtaining public comment. SSA's own regulations admit to this practice. 20 C.F.R. § 422.406(a)(4) specifically states that the "Social Security Rulings" include "statements of policy and interpretations which have been adopted but have *not* been published in the Federal Register . . ." (emphasis added)

There is a very definite need for uniformity of decisionmaking between the various levels of review within SSA. Apparently recognizing that use of the lowliest of SSA documents to issue policy (such as the Program Operations Manual System, Informational Digest, and quality assurance "returns"[10]), may not be acceptable to the Congress or the courts, SSA in the past year has moved toward utilizing the "Social Security Rulings" as the source of all policy. As noted earlier, Rulings contain policy never published in the Federal Register or the federal regulations. They have also been the vehicle for SSA's formal rulings of non-acquiescence. (See, pp. 16–19.)

The Rulings are not the answer to SSA's or beneficiaries' problems with the system. The public notice and comment process is well-suited to SSA's needs.

Due to the size of the Social Security and SSI programs, there are many individuals and organizations with substantial expertise whose opinions and suggestions should be considered, with the likely result of changes or modifications being made in proposals. With rare exceptions for those instances when there is no time for public comment before implementation, it is generally more useful for SSA or any agency to receive comments before a proposal is implemented, before the agency is locked-in administratively to a particular program or approach.

We have no reason to believe that the process for issuing policy changes will be any longer or shorter than the time which SSA currently takes to issue proposed regulations, Social Security Rulings, or other memos. In some cases, the time seems to vascillate wildly, depending upon SSA's motivation. For example, last August SSA issued interim final regulations exempting burial trusts from resources in SSI, long before a somewhat similar provision had even been enacted, but only shortly after the plight of an elderly women, Mattie Dudley, became national news. At the opposite end of the spectrum, it appears that some of the Rulings issued by SSA recently have been in the drafting stages for at least a year.

Given this time frame, there is no excuse for not seeking and obtaining public comment. Proof of SSA's capabilities in quick drafting and issuance of materials was provided to us in somewhat unusual fashion last September. On September 20, 1982, SSA issued a "delayed implementation transmittal" to all SSA staff.[11] In that transmittal, SSA informed local SSA offices that it expected to obtain authority, through either the 1983 appropriations bill or a continuing resolution, to suspend its obligation under § 206 of the Social Security Act, 42 U.S.C. § 406, to withhold 25 percent of a back award to assure that a private attorney's fees are paid. The 18-page, single-spaced, memo detailed how this policy would affect even fees already awarded but not yet paid. SSA had no legislative authority for the transmittal when it was issued nor did it ever receive it. Yet, upon the expectation that it would obtain such authority, SSA staff churned out one of the most detailed, comprehensive documents it has issued in recent years. We can only conclude that, when motivated to do so, SSA can streamline its process and easily obtain the benefit of public comment. We encourage this Subcommittee to require SSA to utilize the APA fully rather than simply acquiescing to its current sluggish, inverted mechanisms for creating and establishing policy.

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[10] *See Mental Health Association of Minnesota* v. *Schweiker*, 554 F. Supp. 157 (D. Minn. 1982).

[11] SSA Pub. No. 68-0203910 (Sept. 20, 1982).

B. SSA should be required to follow the decisions of the Circuit Courts of Appeals unless they are overruled by the Supreme Court

We have addressed this problem in some detail in previous testimony before this Subcommittee.[12] Despite the arrogance and illegality of SSA's policy of non-acquiescing in the decisions of Circuit Courts of Appeals, SSA persists in defending it and continuing its use.

SSA's non-acquiescence policy takes two forms. First, SSA issues “Social Security Rulings” in which it will set forth a circuit court's decision and then state that “SSA *holds* that” it will not follow the court's order. (emphasis in original) This is known in the field as “formal non-acquiescence.” Second, SSA simply ignores many decisions of Circuit Courts with which it disagrees, “informal non-acquiescence”. This has happened on subjects such as the consideration of pain, weight to be given a treating physician's report, and evaluation of alcoholism. Regardless of the form, the practice should be eliminated.

At least four courts have not considered the issue and have ruled SSA's practice null and void; SSA is bound to follow the law of the circuit. *Lopez* v. *Heckler*, Civ. No. 83-0697-WPG(T) (C.D. Cal. June 16, 1983); *Siedlecki* v. *Schweiker*, Civ. Action No. C82-61R (W.D.Wash. January 28, 1983); *Chee* v. *Schweiker*, No. CIV-82-693-PCT-VAC (D.Ariz. December 14, 1982); *Hollingsworth* v. *Schweiker*, No. N81-0035C (E.D.Mo. March 3, 1983). In *Lopez*, the court stated, “[F]or the Secretary to make the general assertion that a decision of the Court of Appeals is not to be followed because she disagrees with it is to operate outside the law.” As a result of this court's order, approximately 72,000 individuals terminated from the OASDI and SSI disability programs who reside within the Ninth Circuit are now entitled to have their cases redetermined under the standards enunciated in *Finnegan* v. *Mathews*, 641 F.2d 1340 (9th Cir. 1981), and *Patti* v. *Schweiker*, 669 F.nd 582 (9th Cir. 1982).

A statutory prohibiton against SSA's non-acquiescence policy is critical. Without it, SSA will continue to hold itself above the law. Two concerns are sometimes raised when SSA's non-acquiescence policy is addressed. First, doesn't the IRS issue rulings of non-acquiescence? Second, if SSA is to be a nationwide program, shouldn't it be administered uniformly?

The Internal Revenue Service does have a non-acquiescence policy. However, it is very different and more sensible than SSA's. For example, if the IRS issues a ruling stating that it non-acquiesces in a circuit court's decision, that ruling is applicable outside of that circuit. The IRS will follow the circuit court's decision within the circuit. SSA, of course, issues its ruling of non-acquiescence to assure that no one within the jurisidiction of the Circuit Court will follow the court's decision. Attached to this statement is an excellent summary of the IRS' practice, prepared by Elena H. Ackel, Senior Attorney, Legal Aid Foundation of Los Angeles, and presented to the Subcommittee on Oversight of Government Management, Committee on Governmental Affairs, U.S. Senate, June 8, 1983. [The attachment follows:]

“Footnote 11, from “Statement of Elena Ackel, Senior Attorney, Legal Aid Foundation of Los Angeles”, before the Subcommittee on Oversight of Government Management, Senate Committee on Governmental Affairs, June 8, 1983:

“[11] Social Security's argument that it is entitled to nonacquiescence in circuit court decisions because the Internal Revenue Service nonacquiescence bespeaks a failure to understand the IRS system and a failure to understand the differences between the two agencies:

“1. The IRS does in fact follow Federal circuit court decisions within the jurisdiction of the circuit deciding the case. (Source: conversation with Joe Gerber, Deputy Chief Counsel for Internal Revenue Service on June 6, 1983.)

“(a) When the IRS issues a nonacquiescence ruling, with respect to a circuit court decision, it is announcing that it will not follow the precedent of one circuit court in other circuits.

“(b) When the IRS issues an acquiescence ruling, it is announcing that it will follow the precedent of one circuit court decision in other circuits.

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[12] “Social Security Appeals and Case Review Process,” Hearings before the Subcommittee on Social Security of the Committee on Ways and Means, October 23 and 28, 1981, Serial 97-31, pp. 200-209, in particular pp. 206-207; “Disability Amendments of 1982,” Hearings before the Subcommittee on Social Security of the Committee on Ways and Means on H.R. 5700, Mar. 16 and 17, 1982, serial 97-54, pp. 209-230, particularly 218-220, 228-230.

"2. The IRS policy of nonacquiescence applies primarily to Tax Court decisions. The Tax Court is an Article I decision-making body and thus is an agency within the Executive Branch. It is not an Article III body. The announcements of acquiescence or nonacquiescence have been an attempt to let the public know what the IRS policy is concerning a Tax Court ruling.

"3. Where the IRS disagrees with a circuit court's ruling on an issue, the IRS follows a policy of litigating the issue in other circuits in order to create a split among the circuits so as to create a ground for Supreme Court review. Unlike Social Security, the IRS does not ignore the precedent with which it may disagree.

"4. There are multiple fora in which a tax litigant may pursue a claim. A claimant may take a dispute over taxes to Tax Court before paying. The Tax Court is a court of National jurisdiction which sits in various cities around the country. A claimant may also pay the amount owed and then sue for a refund in the Court of Claims in Washington, D.C. or in the district court where the claimant resides. Even if the IRS were not to follow the decisions of a court of appeals within a particular circuit (which in fact is not the case), a tax litigant is in a far stronger position than a Social Security claimant who cannot forum shop as can the tax litigant.

"5. Even the Tax Court, which is an agency within the Executive Branch, must follow the law of the circuit court in the jurisdiction of that court. *Golsen* v. *Commissioner,* 54 Tax Reporter 742 (1970).

"In summary, an examination of IRS practice leads to a rejection of Social Security's practice of nonacquiescing in circuit court decisions with which it disagrees."

On the question of nationwide uniformity, it should be noted that the policy considerations in support of nationwide taxation policies are no less substantial than those favoring nationwide standards in Social Security. In *Califano* v. *Yamasaki,* 442 U.S. 682,669 (1979), SSA informed the Supreme Court that it would follow the decisions of circuit courts of appeals, regardless of whether a class had been certified. "Restricted judicial review will not have a detrimental effect on the administration of the Social Security Act, the Secretary says, because he will appeal adverse decisions or abide [by] them within the jurisdiction of the courts rendering them." Further, in the same case, in an effort to avoid certification of a nationwide class, SSA argued *for* the need for diversity of circuit court opinions:

> [The Secretary] argues that a nationwide class is unwise in that *it forecloses reasoned consideration of the same issues by other federal courts* and artificially increases the pressure on the docket of this Court by endowing with national importance issues that, if adjudicated in a narrower context, might not require our immediate attention. 442 U.S. at 701-702.

SSA cannot have it both ways. Based upon its own respresentation, SSA is not really that concerned about the uniformity issue. While it is desirable that the program be administered uniformly nationwide, it is more desirable that SSA follow the law of the Circuit within that Circuit until such time as the Supreme Court rules to the contrary in that case or another case raising the same issue.

C. SSA should be specifically required by statute to issue regulations governing the use and monitoring of consultative examinations

§ 304 of P.L. 96-265, the Social Security Amendments of 1980, provided that the Secretary of HHS "shall promulgate regulations specifying, in such detail as he deems appropriate, performance standards and administrative requirements and procedures to be followed in performing the disability determination function in order to assure effective and uniform administration of the disability insurance program throughout the United States." When SSA did issue proposed regulations governing the federal-state agency relationship, it did not mention consultative examinations (CE) or set standards for their utilization. This is so despite the incredibly high administrative cost incurred in paying for CEs, over $137 million in 1981 alone.[13] (As the number of CDI reviews increased last year, it is likely that this figure increased substantially in 1982.)

The problem with the CE process have been documented at numerous earlier hearings of this Subcommittee, including those focusing solely on the volume provider CE problems. We are aware that SSA has recently prepared a sheet which describes in the vaguest of terms the steps which it has taken in this area. While it is impossible for us to tell from the sheet whether SSA has made significant changes, the calls to our office regarding the poor quality of decisions has not been reduced. Further, there is no mention of the issuance of regulations.

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[13] Statement of Sandy Crank, Associate Commissioner for Operational Policy and Procedures, Social Security Administration, "Volume Providers of Medical Examinations for Social Security Disability Programs," Ways and Means Committee, Serial 97-27, p. 12 (September 21, 1981).

We are ware of lawsuits being filed against HHS, state agencies and CEs by the surviving spouses of disabled workers who died shortly after a CE said they were not disabled and SSA terminated their benefits. It is unfortunate that such suits must be filed, particularly for the disabled worker who cannot regain his life, but if SSA does not regulate this area and improve the quality of CE evaluations, it is reasonable to expect that the litigation in this area will increase.

D. The face-to-face interview should be conducted at the initial level of review

H.R. 2987 includes a provision which will move the face-to-face interview up to the initial level of review. The disabled person will be interviewed, actually observed and listen to, by the state agency official adjudicating the person's case. This provision should increase the quality of decisionmaking at the initial level and obviate the need for many of the appeals currently being filed.

We do not believe that a face-to-face interview at the reconsideration level serves the same purposes. It will take place only after there has been a decision against the applicant or recipient. It is far more logical to obtain the most complete evidence development, including a meeting with the applicant or recipient, at the earliest stage possible.

We are also concerned about the implications which creation of this level of review have for continuation of aid pending an ALJ's decision. Currently, SSI benefits continue through the ALJ level; there is no reconsideration level in SSI disability termination cases. It is our understanding that SSA now intends to include a reconsideration level in SSI disability termination cases. It is our understanding that SSA now intends to include a reconsideration level for these SSI cases and only pay aid pending through this level. While there may be some constitutional problems with this approach, it also does not represent good public policy. As the ALJ level is the first level at which an individual's case is reviewed by an impartial trier of fact whose job is secured by statute for life, it is more appropriate to provide aid pending through this level where the highest degree and accuracy and fairness are assured.

In the context of OASDI, we believe it would be a serious mistake to cut back the aid pending provision to cover only the reconsideration level. Section 202 of H.R. 2987 represents a better solution. First, while the pilot projects reflected a higher reversal rate (34 percent) than had previously existed at the reconsideration level, almost half of that figure reflects reversals made by the state agency before the file had even been sent to the federal level for the face-to-face interview. It is reasonable to expect that the reversal rate will be substantially less when the initial interest in the new level dissipates. Second, SSA staff have indicated a belief that the reconsideration decisions can be completely expeditious, within two months. This is extremely convenient: Currently, by statute, OASDI disability benefits continue for two months after the date of cessation. In other words, there would be no real right to aid pending. In addition, we expect that, given the convenience of this time frame, there would be a great deal of pressure to issue decisions within the two month period, even where the files had not been fully developed and/or fully reviewed. The possibilities for abuse are substantial. At a minimum, it would be helpful if aid paid pending the ALJ level is continued for the next two to three years until the experience with this new level of review, if it is retained, is fully understood.

III. MISCELLANEOUS CONCERNS

There are two additional issues which we believe the Subcommittee should consider:

A. SSA has not properly implemented § 301 of P.L. 96-265, which provided for continued eligiblility for benefits even though the person's impairment has ceased where the person is involved in a vocational rehabilitation program.

B. Private attorneys are currently unclear about how they are to obtain their fees in OASDI cases. As a result, it is possible that some will not be able to continue to provide representation is these cases.

A. SSA is violating § 301 of P.L. 96-265, the 1980 Amendments

While SSA has relied heavily upon Congress' role in 1980 and the alleged Congressional intent in justifying its behavior with the CDIs, SSA has completely obstructed the effects of one provision of P.L. 96-265, designed to assure that those seeking to improve their skills and thus eliminate their reliance upon disability benefits are not discouraged from taking such steps.

Section 301 of the 1980 Social Security amendments, P.L. 96-265, [42 U.S.C. ¶425(b) and §1383(a)(6)] provides that SSA cannot terminate the benefits of a person whose physical or mental impairment has ceased if the person is participating in an approved voc rehab program and SSA determines that involvement in the voc rehab program will increased the likelihood that the person may ultimately be permanently removed from the disability program. But, SSA added an extra reqirement in its regulations. 20 C.F.R. §416.1338(a)(4) only permits benefits to continue in cases where, at the time the person began voc rehab, he/she was "not expected to recover medically before the scheduled completion date of the program." SSA has taken the position that a person whose case was diaried for review on the expectation that there could be improvement is not entitled to the benefits of Section 301 due to §416.1338(a)(4).

Two cases have challenged this policy. *Leshniok* v. *Schwieker,* Civ. No. 82 308 PHX CCH (D. Ariz.), is pending in the 10th Circuit Court of Appeals. In *Paskel* v. *Heckler,* No. 83-1201 (E.D. Pa.), the district court has granted the individual plaintiff's motion for declaratory and injunctive relief. The court held:

> 42 U.S.C. §1383(a)(6) provides that even if a disability beneficiary's impairment has ceased, that individual shall not be terminated if he or she is participating in an approved vocational rehabilitation program and "the Commissioner of Social Security determines that the completion of such program . . . will increase the likelihood that such individual may (following his participation in such program) be permanently removed from the disability benefit rolls." *Id.* The language of this statute is clear on its face. In plain and unmistakable words, free of ambiguity or qualification, it states that persons in vocational rehabilitation programs (which includes the plaintiff) are entitled to a "likelihood" determination before their benefits are terminated.

Data stipulated to by SSA in *Paskel* reflects the enormity of the problems.[14] Despite the fact that thousands of OASDI and SSI disabled beneficiaries in Pennsylvania are actively participating in approved state vocational rehabilitation programs, and despite the fact that hundreds are subjected to CDI reviews each year and many more will be reviewed as a result of the diary process, SSA only performed 4 evaluations in Pennsylvania under §301 in all of 1982, only 2 of which are granted.

The statute should be clarified to assure that SSA properly reviews cases under §301.

B. Steps should be taken to clarify the mechanisms by which private attorneys can obtain their fees in disability cases

We are very concerned that the private bar is having difficulty obtaining its fees in disability cases. We raise the issue for two reasons: (1) due to cuts in legal services programs' budgets and the increasing numbers of individuals needing to appeal terminations and application denials, legal services programs are not able to represent all of the people needing assistance in presenting their cases to SSA, and (2) while very concerned, the private bar seems to feel that any recommendations on the subject it might make would be considered suspect.

We do not make any particular proposals at this time, but recommend that the Subcommittee consider whether changes should be made to assure that an attorney is able to be paid at some point. While not statistically based, our experience is that the private Social Security bar are generally attorneys of relatively modest means, with families to support, who must receive compensation for the majority of their work in order to survive. We are concerned that, without some legislative initiative, fewer attorneys will be available to assist disabled individuals in the often extremely complex and circuitous process of obtaining benefits to which they are entitled from SSA.

IV. SECRETARY HECKLER'S RECENT PROPOSALS DO NOT ADDRESS THE PROBLEMS FACED BY MOST DISABILITY BENEFICIARIES SUBJECTED TO CDI REVIEW

The following is a brief discussion to each of Secretary Heckler's recent proposals along with our concerns about each.

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[14] "Stipulation" dated June 13, 1983, *Paskel* v. *Heckler,* Civil Action No. 83-1201 (E.D. Pa.).

A. SSA has identified new categories of "permanently disabled" individuals who, by virtue of this recategorization, will be exempt from CDI review

We welcome any effort to identify more disabilities as permanently disabling. However, it is very important that the Congress focus on the types of impairments which SSA is now, for the very first time, identifying as permanently disabling. The list includes [15]:

Amputation or permanent loss of use of two limbs;

Amputation of a leg or foot because of diabetes or peripheral vascular disease;

Ischemic heart disease with chest pain of cardiac origin;

Parkinsonian syndrome, with disturbance of movement, gait, or station as required by the applicable listing;

Spinal cord or nerve root lesion resulting in paraplegia or quadriplegia, damage to the spinal cord or major branches resulting in markedly reduced function in two or more extremities;

Multiple Sclerosis, damage to the nervous system due to areas of inflamation which recur and may progress to interference with function of the nervous system, including severe weakness, paralysis;

Anterior poliomyelitis, with interference in swallowing, breathing, speech, or motor function as described in the applicable listing;

Muscular dystrophy, a chronic progressive disease causing irreversible wasting of the muscles with a significant effect on the ability to use the arms and/or legs;

Chronic brain syndrome (organic brain syndrome) with manifestations as required by the applicable listing;

Functional psychotic disorders if institutionalized in a licensed mental hospital for past 12 months without releases that would indicate improvement;

Severe mental retardation, with manifestations as required by the applicable listing.

It is troubling to imagine that anyone, much less SSA, had difficulty in determining that these impairments were permanently disabling. Yet, less than one month ago, and since March 1981, SSA has been reviewing the cases of individuals with exactly these impairments and, we believe, terminating many of their cases. One can only wonder how many of the deaths after notice of termination could have been prevented had SSA not been so eager to terminate so many. Given this SSA action at this late date, SSA should be required to go back and review the cases of recipients whose benefits were terminated who suffer from impairments just added to this list. As noted earlier, this category has the benefit of a medical improvement standard not available to the vast majority of OASDI and SSI beneficiaries. If they had originally been in that category, in all likelihood, their benefits would still be being paid. But, those who did not have the benefit of the medical improvement standard were often told instead that their impairments were "not severe." These cases that were terminated should be reviewed immediately and benefits should be reinstated.

B. SSA will propose legislation that benefits be continued through the reconsideration level of review and that SSA will be required to review state agency decisions denying benefits as well as allowing benefits.

The problems with providing aid pending only through the reconsideration level are discussed earlier in our testimony. Further, while the terms of P.L. 97-455 are temporary, this proposal represents a cut from the current payment scheme.

We agree that it would be helpful for SSA to review state agency denials as well as allowances. It is our understanding that SSA is already doing that to some extent. This proposal was first made over one year ago at this Subcommittee's hearing on March 16, 1982 by Commissioner Svahn.

C. SSA will "study" whether changes should be made with regard to evaluation of severity of impairment and possible use of medical improvement standard

These issues are discussed earlier in our statement. The time for "study" of these issues was exhausted long ago. SSA has been involved in litigation on these issues and has lobbied the Congress with regard to various formulations of solutions. In addition, it has ongoing familiarity with the "medical improvement" standard. The Subcommittee should adopt the provisions of H.R. 2987 which address these issues.

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[15] Source: "Emergency DI/SSI Instructions," OD-83-145 (1027), IT-159-83, June 11, 1983 ("corrected copy").

D. SSA will no longer rely upon the computer "profile currently used to identify cases for CDI review and will instead use a random sample

We believe that at this point eliminating the profile is a hollow gesture. The profile is weighted for younger workers with high earnings before they were disabled. As a result, after over two years of use, it has generally already exhausted its usefulness. While SSA points out that the profile weighs factors such as age and previous earnings and therefore will continue to move up the age and down the earnings scales, they are not able to state how many people will benefit from the shift. Over two years into the process, there probably is no difference between the profile and a random sample.

E. SSA will "pause" CDI review of 135,000 people who suffer from "functional psychotic disorders" while SSA reviews the standards it has been utilizing in these cases

A moratorium or pause on the CDI reviews of mentally impaired individuals' cases makes sense if one looks at the 50 percent appeal rate to the ALJ level. We assume that this rate is so low not because SSA is accurately deciding cases but because confused people, largely with mental impairments, are not protecting their right to appeal. Recent court decisions, requiring SSA to reopen decisions where mentally impaired individuals failed to appeal support this analysis. See, for example, *Penner* v. *Schweiker,* No. 82-5337 (3d Cir. February 28, 1983); *Kapp* v. *Schweiker,* 556 F. Supp. 10 (N.D. Cal. 1981); *Brittingham* v. *Schweiker,* Civil Action No. 82-4632 (E.D. Pa. February 7, 1983).

The Secretary's proposal raises two concerns. First, it seems inappropriate to distinguish among the mentally impaired. Further, as a practical matter, if SSA's decisions as to who will be entitled to a "pause" are based upon its often shoddily developed records, SSA is likely to deny a pause were it should be granted.

Second, we are concerned that any pause or moratorium for the mentally impaired not simply result in more physically impaired people's cases being rushed through the CDI process. It would be helpful if SSA simply reduced the overall number of CDIs which it expects to complete this year.

Chairman PICKLE. Now, Mr. Manes, would you proceed?

Mr. Manes is senior policy analyst for the mental health law project.

Where are you located?

Mr. MANES. In Washington.

Chairman PICKLE. Please proceed.

STATEMENT OF JOSEPH MANES, SENIOR POLICY ANALYST, MENTAL HEALTH LAW PROJECT

Mr. MANES. My testimony reflects the mental health law project's experience as counsel for plaintiffs in three class actions in Minnesota, Utah, and New York. My written testimony has been submitted and I will summarize it briefly. Mr. Fried has dealt with several of the issues that I will also talk about, so my testimony will in fact be a reinforcement of his.

In our case in Minnesota as well as Utah, and New York, our research has consistently demonstrated that the Social Security Administration shortcircuits the Social Security Act and its regulations during the conduct of continuing disability investigations particularly with respect to determination of ability to work.

The Social Security Administration has communicated a new standard to its regional offices and State agencies; namely, that mentally impaired claimants under the age of 50 who did not meet SSA's listing of impairments were presumed capable of at least unskilled work.

This presumption almost invariably resulted in denial of disability benefits. In its preliminary ruling in *Mental Health Association of Minnesota* v. *Schweicker*, decided last December, the court found that:

> SSA has no medical, vocational or other empirical or scientific basis for presuming that a mentally impaired person whose condition does not meet or equal the listings retains the residual functional capacity to work.

The court issued a far-reaching injunction applicable to the six States of SSA Chicago region against continiung application of this presumption. The court ordered SSA to restore benefits to all mentally disabled persons who were adversely affected by CDI's since March 1981 and to reevaluate their eligibility. Documentation of almost identical practices in Utah and New York demonstrate that this policy of presumption was not the "aberration" SSA claimed in its defense, only practiced in the Chicago region, but a firm national SSA policy—one which had been in place for several years, antedating the Reagan administration, in fact.

As early as August 1978, the chief consulting psychiatrist in the New York regional office, Dr. Anne Geller, wrote in an internal memo, "It is clear that whether a claimant can withstand the stress of work or not is never a consideration. Unfortunately there are the guidelines we have to follow even though common sense and psychiatric experience dictate otherwise." She went on to say, "I therefore conclude that in younger workers medical-vocational allowances are not considered when the impairment is psychiatric." This was August 1978.

In Utah we are halfway through a review of all initial applications of mentally impaired persons and have yet to find one disability finding based on a medical-vocational evaluation.

We believe that such neglect of the required sequential valuation process can be corrected ony through legislation. In the Shannon-Stark bill, H.R. 2987, several sections require a realistic evaluation of each claimant's ability to work. For mentally disabled individuals, section 104 requires a work evaluation at an actual or simulated worksite. We endorse this requirement.

Section 105 prohibits the practice of improperly equating the capacity to do sheltered work with the ability to hold a competitive job. The amendment in the Shannon bill recognizes the substantial difference between success in a nonstressful supportive workshop environment and success in the competitive job market.

Insights about an individual's performance and capability could still be used to assist SSA in reaching a decision, but no one should be presumed capable of working simply by virtue of participation in noncompetitive work.

A third provision in the Shannon bill related to determination of ability to work is addressed in section 204 of the bill. The section requires SSA to consider the complete medical and vocational history of the applicant including all evidence in the file from prior evaluations in situations of long-term illness, particularly chronic mental illness, which often follows an erratic course; SSA has mistakenly accepted temporary improvement as representing an end to the disability.

Our cases have demonstrated clearly that SSA has no procedures, no organized method of evaluating ability to work for mentally impaired persons.

The second item in my testimony that I would like to emphasize deals with the topic we have discussed previously—uniform administrative standards and noncompliance with court orders.

We have devised in this country a system of administrative regulation-setting and adjudicative procedures designed to assure compliance with the intent of Congress and the terms of the Constitution, to protect the interests of program beneficiaries and the public, and to achieve effective administration of the law by public agencies.

It is a balanced system and one that most Federal agencies have been able to live with. SSA, however, has aggressively and consistently attempted to circumvent the established process by its policies of nonacquiescence in decisions by the circuit court of appeals and by issuance of POM's, rulings, and memorandums which spell out new policies or revise existing ones for DDS agencies. SSA has created its own unique system of rules and regulations which almost totally avoids the Administrative Procedure Act and its rulemaking safeguards.

State DDS officials have testified in depositions that commonly they discover changes in SSA policy through quality assurance reviews by SSA. By analyzing the decisions which SSA overturn, the DDS discerns the current policy it is expected to apply. SSA's system of rulemaking for the State DDS agencies is not recognized by either the administrative law judges or the Federal courts which rely on the law and published regulations.

It is not surprising therefore that conflicting decisions result from such inconsistent decisions making criteria used at the different levels in the process. The Shannon-Stark bill, in section 301, opts for Federal regulations through the APA as the appropriate policymaking vehicle. It requires application of a single uniform set of standards at all levels of the disability determination process.

Committee report language should make it clear that all parts of the adjudicative system must operate under the same set of requirements and that the law and pubished Federal regulations are binding on State agencies.

Section 302 of the Shannon bill would complete the task of bringing the Social Security Administration into the national system of rules and procedures. It requires SSA to either apply the decision of a circuit court of appeals involving issues of statutory or regulatory interpretation to all beneficiaries within the circuit or to request review of the decision by the Supreme Court.

If the Supreme Court does not review the case, the decision of the circuit court will be binding upon the States in the circuit until and unless the Supreme Court rules to the contrary. We endorse this approach and urge the committee to adopt it.

I have not addressed in my testimony all the provisions of the Shannon-Stark bill. I have concentrated on those sections in which the mental health law project has developed special knowledge based on our participation in litigation across the country. However, we join the other disability organizations in fully endorsing H.R. 2987. It represents a coherent, well-considered approach to permanent resolution of the accumulated difficulties that have plagued the disability determination process.

Thank you.

[The prepared statement follows:]

STATEMENT OF JOSEPH MANES, MENTAL HEALTH LAW PROJECT

My name is Joseph Manes. I am senior policy analyst with the Mental Health Law Project, a not-for-profit public-interest organization that represents mentally ill and developmentally disabled persons and those so labeled. On behalf of the project, I appreciate the opportunity to testify with respect to proposed reforms in the disability insurance program. My testimony reflects MHLP's experience as counsel for plaintiffs in three class actions in Minnesota, Utah and New York. These cases involve challenges to the social security administration's termination for the disability rolls of mentally disabled recipients. In the case of *Mental Health Association of Minnesota* v. *Schweiker,* 554 F. Supp. 157 (D Minn. 1982), a federal district court has ordered SSA to revise its standards for determining mental disability and re-evaluate all cases of denial or termination of benefits to mentally disabled persons. The other two cases are in earlier stages of litigation.

Mr. Chairman, you are to be commended for the openness you have shown to the legislative proposals of the groups representing the interests of our disabled citizens. We have had full and productive meetings with you and your staff prior to the hearing and we hope to continue such cooperative efforts.

SECRETARY HECKLER'S REFORMS

The changes in the disability determination process announced on June 7 by Secretary Heckler are superficial and inadequate. And it appears that even these changes have been grudgingly proposed only as a concession to the disability groups and the Congress, based on extensive and continuing revelations of unwarranted termination of benefits to severly disabled citizens.

The changes announced by the Secretary are designed to deal with immediate pressures; they do not address the basic concerns that have been widely identified and validated. In fact, in some respects, the proposals diminish the already inadequate protections afforded mentally disabled psersons. The short-term remedies enacted by Congress last December (PL 97-455) allow individuals whose benefits are terminated and who exercise their right of appeal to an administrative law judge to continue receiving payments until the appeal process is completed. The administration now proposes to make this provision permanent—but to maintain benefits only through reconsideration review (the first level of appeal). Because of backlogs over the past year, appeals to an administrative law judge have taken six to nine months. Under the Secretary's proposal, the individual would be without benefits for that period of time. It is worth noting that two-thirds of these appeals have produced reversal of the initial termination and retroactive payment of benefits. This proposal is inexplicable in terms of the Secretary's stated goal of making the process more humane.

Of course, we do not discount the Secretary's exemption—Temporary or permanent—of an estimated 335,000 mentally and physically impaired individuals from the process of continuing disability investigation (CDI). The Secretary's proposals will serve these citizens well. But for the remaining one and one-half to two million persons who must still experience a CDI and for the hundreds of thousands who will apply for disability benefits over the next few years, basic reforms are required.

H.R. 2987: SOCIAL SECURITY DISABILITY DETERMINATION REFORM ACT OF 1983

H.R. 2987, the legislation introduced by Congressmen Shannon and Stark to fundamentally reform the Social Security disability determination process, has been endorsed by 40 national organizations representing disabiity groups along with medical and other mental health professional, consumer and citizen groups and the Save Our Security Coalition. The remainder of my testimony will address several aspects of that legislation about which the mental Health Law Project has gained insights through its litigation during the past two years. A section-by-section analysis of H.R. 2987 accompanies my testimony. With your permission, I would insert that analysis in the record.

DETERMINATION OF ABILITY TO WORK

Our research in the three class actions in Minnesota, Utah and New York has consistently demonstrated that the Social Security Administration short-circuits the Social Security Act and its regulations during the conduct of continuing disability investigations. SSA has communicated a new standard to its regional offices and state agencies: Mentally impaired claimants under the age of 50 who did not meet SSA's "Listing of Impairments" were *presumed* capable of at least unskilled work. This presumption almost invariably resulted in denial of disability benefits. In its preliminary ruling in *Mental Health Association of Minnesota* V. *Schweiker*, the court found that "SSA has no medical, vocational or other empirical or scientific basis for presuming the a mentally impaired person whose condition does not meet or equal the Listing retains the residual functional capacity to work." The court issued a far-reaching injunction, applicable to the six states of SSA's Chicago region, against continued application of this presumption. The court ordered SSA to restore benefits to all mentally disabled persons who were adversely affected by CDIs since March 1981 and to re-evaluate their eligibility.

Documentation of almost identical practices in Utah and New York demonstrates that the policy of presumption was not the "aberration" SSA claimed in its defense, only practiced in the Chicago region, but a firm national SSA policy—one which has been in place for several years. As early as August 1978, the chief consulting psychiatrist in the New York regional office, Dr. Anne Geller, wrote: "It is clear that whether a claimant can withstand the stress of work or not is never a consideration. Unfortunately there are the guidelines we have to follow even though common sense and psychiatric experience dictate otherwise." She went on to say, "I therefore conclude that in younger workers medical-vocational allowances are not considered when the impairment is psychiatric." [Internal memorandum, N.Y. Regional Office, August 24, 1978] In Utah we are halfway through a review of all initial applications of mentally impaired persons and have yet to see one disability finding based on a medical-vocational evaluation.

We believe that such neglect of the required sequential evaluation process can be corrected only through legislation. In H.R. 2987, several amendment sections require a realistic evaluation of each claimant's ability to work. For mentally disabled individuals, section 104 requires a work evaluation, at an actual or simulated work site. We endorse this requirement, and further urge Committee-report language to make clear that an appropriate work evaluation must include (1) an in-depth interview to obtain a claimant's detailed work, education and social history; (2) a comprehensive medical and psychological evaluation; (3) vocational and work-sample testing to determine how the individual performs in an actual or simulated work setting; and (4) where a physical impairment exists in addition to a mental impairment, an evaluation of physical capacity performed by a licensed occupational therapist under the direction of a physician.

The Shannon-Stark bill, in section 105, would also prohibit the practice of improperly equating the capacity to do sheltered work with ability to hold a competitive job. The amendment recognizes the substantial differences between success in a nonstressful, supportive workshop environment and success in the competitive job market. Insights about the individual's performance and capabilities could still be used to assist SSA in reaching a decision, but no one could be presumed capable of working simply by virtue of participation in noncompetitive work.

A third provision related to the determination of ability to work is addressed in section 204 of the bill. This section requires SSA to consider the complete medical and vocational history of the applicant, including all evidence in the file from prior evaluations. In situations of long-term illness—particularly chronic mental illness, which often follows an erratic course—SSA has mistakenly accepted temporary improvement as representing an end of the disability.

MEDICAL IMPROVEMENT

The Shannon-Stark bill provides, in section 101, that before a person's disability benefits can be terminated, there must be a finding supported by clear and convincing evidence that (A) there has been sufficient medical improvement, enabling the person to perform substantial gainful activity (SGA), or (B) the person has benefited from advances in medical or vocational therapy or technology, resulting in his ability to perform SGA. Under the current SSA approach, an individual who has been on the rolls for several years is treated the same as a new applicant. No weight is given to the original determination of disability even though it was valid at the time rendered. Some courts have required the Secretary to continue benefits unless there is evidence that the person has improved medically or that the original decision was clearly erroneous. SSA, however, has refused to apply this standard. The Shannon-Stark proposal provides a sensible remedy for severely disabled individuals whose benefits are now being terminated despite the lack of medical improvement.

PRETERMINATION NOTICE AND RIGHT TO PERSONAL APPEARANCE

As currently structured, the disability determination process does not permit the disabled individual to meet personally with the decisionmaker until the ALJ review level. Under PL 97-455, a face-to-face interview was added at the reconsideration level. The Shannon-Stark bill correctly concludes that a face-to-face interview at the initial determination stage is more effective and efficient. In an interview, the examiner can personally assess the individual's limitations, while the disabled person has an opportunity to rebut the preliminary notice of termination with additional medical or other information. To avoid unnecessary duplication of effort and expense, the reconsideration level of review would be eliminated.

We are advised that the reconsideration review takes about seven hours. A face-to-face interview at the initial level would be significantly less time-consuming and therefore less costly. Furthermore, it would enhance the applicants' perception of the fairness of the process, leading, in all likelihood, to a reduction in ALJ appeals. Secretary Heckler, in her statement on June 7, came out vigorously against a "paper oriented review process" as being "too insensitive, too bureaucratic. Mistakes were too easy to make and too hard to rectify." Establishing a face-to-face meeting between the initial decisionmaker and the applicant is entirely in the spirit of Secretary Heckler's approach.

UNIFORM STANDARDS AND COMPLIANCE WITH COURT ORDERS

We have devised a system of administrative regulation-setting and adjudicative procedures designed to assure compliance with the intent of Congress and the terms of the Constitution, to protect the interests of program beneficiaries and the public, and to achieve effective administration of the law by public agencies. It is a balanced system and most federal agencies have been able to live with it. SSA, however, has aggressively and consistently attempted to circumvent the established process. By its policies of nonacquiescence in decisions of the circuit courts of appeals and by issuance of POMs, rulings and memoranda which spell out new policies or revise existing ones to keep DDS agencies in line, SSA has created its own unique system of rules and regulations while almost totally avoiding the Administrative Procedure Act (APA) and its rulemaking safeguards.

State DDS officials have testified in depositions that commonly they discover changes in SSA policy through quality assurance reviews by SSA. By analyzing the decisions SSA overturns, the DDS discerns the current policy it is expected to apply.

SSA's unique system of rulemaking for the state DDS agencies is not recognized by either the administrative law judges or the federal courts, which rely on the law and published regulations. Conflicting decisions result from such inconsistent decisionmaking criteria used at the diffenent levels in the process.

The Shannon-Stark bill, in section 301, opts for federal regulations through the APA as the appropriate policymaking vehicle. It requires application of a single, uniform set of standards to all levels of the disability determination process. Committee report language should make it clear that all parts of the adjudicative system must operate under the same set of requirements and that the law and published federal regulations are binding on state agencies. SSA can continue to use the POMs or other informal means of transmitting—but no revising—agency procedures and explanations of the rules to state DDS staffs.

Section 302 would complete the task of bringing the Social Security Administration into the national system or rules and procedures. It requires SSA either to apply the decision of a circuit court of appeals involving issues of statutory and regulatory interpretation to all beneficiaries within the circuit or the request review of the decision by the Supreme Court. If the Supreme Court does not review the case, the decision of the circuit court will be binding upon the states in the circuit until and unless the Supreme Court rules to the contrary in that case or another comparable case.

My testimony, Mr. Chairman, has not addressed all the provisions of the Shannon-Stark bill. I have concentrated on those sections in which the Mental Health Law Project has developed special knowledge based upon our participation in litigation across the country. However, we join with the other disability organizations in fully endorsing HR 2987. It represents a coherent, well-considered approach to permanent resolution of the accumulated difficulties that have plagued the disability determination process. Thank you.

The Mental Health Law Project's ALERT

EXPLANATION AND SUMMARY OF HR 2987, A BILL TO REFORM THE DISABILITY DETERMINATION PROCESS

June 10, 1983

On May 11, 1983, Congressmen James Shannon (D-MA) and Fortney (Pete) H. Stark (D-CA) introduced HR 2987, the Social Security Disability Determination Reform Act of 1983. The bill reflects proposals developed by a coalition of organizations representing disabled persons and their families, advocacy organizations, medical and other professional mental health and developmental disability groups. The Shannon-Stark bill will be examined late in June at a hearing of the Social Security Subcommittee of the Ways and Means Committee, chaired by Congressman J. J. Pickle (D-TX). HR 2987 is of sufficient importance to warrant a section-by-section summary of its most significant provisions, including an explanation of the problem in the existing disability determination process (as gleaned from proceedings in SSA litigation, congressional hearings and GAO reports) that generated each amendment.

Problem	HR 2987 Amendment
Section 101: Standard of Review	
Since 1979, SSA has taken the position that disabled recipients must establish their continuing disability under current standards. As a result, benefits have often been terminated without evidence of medical improvement or even when the person's condition has deteriorated since the original determination of disability. Someone who has been on the rolls several years is treated the same as a new applicant. Medical or other documentation more than one year old is often not considered and no weight is given to the original determination of disability, even though it was valid at the time rendered.	Disability benefits can be terminated only with clear and convincing evidence of (a) significant medical improvement which enables the person to perform substantial gainful activity (SGA) or (b) new medical evidence and a new assessment of residual functional capacity (RFC) showing that the person has benefited from advances in medical or vocational therapy or technology, making him able to perform SGA or (c) the prior decision was clearly erroneous or fraudulently obtained or (d) the person is currently performing substantial gainful activity.
Section 102: Multiple Impairments	
SSA considers the combined effect of impairments only when all are severe. Individuals suffering from a variety of serious problems, none of which meets the test for a severe impairment, are thus ineligible for benefits.	The combined effects of impairments may be considered in determining whether someone can work, even if none of the impairments, considered seperately, is severe.
Section 103: Evaluation of Pain	
Severe and persistent pain is taken into account only if fully explained by laboratory or diagnostic procedures, although diagnostic and clinical techniques often cannot verify or deny the existence of pain Otherwise, debilitating pain is discounted.	Debilitating pain or other symptoms such as dizziness and numbness may lead to a finding of disability, even when diagnostic techniques fail to fully explain the extent. Subjective evidence of disabling pain and other similar symptoms, if corroborated by the patient's behavior and by family and friends, could be sufficient.

Section 104: Evaluation of Ability to Work

Congressional hearings and investigations show that SSA has relied on inappropriate medical criteria to justify mistaken conclusions about ability to work. The problem is especially acute for mentally impaired people. GAO found that SSA arbitrarily presumes that a mentally ill individual can work if he fails to meet the Listings of Mental Impairments (stringent medical criteria established by SSA).

A finding of disability must be based on a realistic evaluation of the individual's capacity to meet the demands of competitive work on a sustained basis. The amendment requires SSA to seek relevant information from medical, vocational and other sources about capacity to work. A work evaluation is required before a mentally impaired individual can be found not disabled.

Section 105: Consideration Given Non-Competitive Work

SSA improperly equates sheltered work with the ability to hold a competitive job. But, success in a non-stressful, supportive workshop environment is very different from success in the competitive job market.

SSA may not base a conclusion that someone can work solely on employment in a sheltered or non-competitive work environment. SSA can, however, use insights about the individual's performance and capabilities in those settings in reaching a decision.

Section 201: Moratorium on Mental Impairment Reviews

Scientific research and clinical data in psychiatry and rehabilitation psychology demonstrate that neither the Listings of Mental Impairments nor SSA's method of assessing residual functional capacity measures or predicts ability to work. Through use of these inappropriate criteria for mental disability, tens of thousands of mentally disabled persons who cannot work because of their illness have been improperly denied disability benefits.

Continuing disability investigations (CDIs) of mentally impaired recipients are stopped until SSA revises the standards and procedures for evaluating mental impairments consistent with current medical and scientific knowledge. The eligibility of initial applicants evaluated under current criteria and the eligibility of those terminated through a CDI since March 1981 must be redetermined once revised standards are issued through new regulations.

Section 202: Payment of Benefits During Appeal

Even with enactment of comprehensive corrective legislation this year, inequities in the disability review process will not be totally resolved by October 1, 1983, when the continuation-of-benefits provision of PL 97-455 expires. Many disabled persons may still appeal a non-disability finding. Eligibility for cash benefits and Medicare services during appeal is needed to prevent recurrence of the terrible financial and emotional hardships suffered by disabled persons prior to PL 97-455.

PL 97-455 provisions relating to continuation of benefits and Medicare eligibility through the administrative law judge (ALJ) hearing are made permanent. The amendment also authorizes continuation of benefits and Medicare eligibility through the appeals council review when the council has decided to review an ALJ decision favorable to the appellant.

Section 203: Pre-Termination Notice and Right to Personal Appearance

The disabled individual does not meet personally with the decisionmaker until the ALJ level of review. PL 97-455 added a face-to-face interview at the reconsideration level. However, a face-to-face interview is more effective and efficient at the initial determination stage, so the examiner can personally assess the individual's limitations and the disabled person can rebut the initial findings with additional information.

The state DDS must give a disabled person detailed notice of any intended decision that is wholly or partly unfavorable and must inform the person that he has 30 days to request a personal interview and provide additional medical or other evidence. After the interview, the state agency will issue a final decision affirming, modifying or reversing its preliminary notice. Appeal of an unfavorable decision will go directly to an ALJ. The reconsideration level of review is eliminated as unnecessary and duplicative.

Section 204: Case Development and Medical Evidence

In situations of long-term illness -- particularly chronic mental illness, which often follows an erratic course -- SSA has mistakenly interpreted temporary improvement as an end to the disability. The error results from SSA's use of a contract physician who is unfamiliar with the beneficiary's illness and medical history. The decision often ignores prior medical evaluations.

In reviewing eligibility, SSA must consider the complete medical and vocational history, including all evidence in the file from prior evaluations. SSA must also develop a complete medical history of the person being reviewed, covering the preceding 12 months. Every reasonable effort must be made to obtain information from the beneficiary's physician before a consultative examination is ordered.

Section 205: Assistance with the CDI Process

Many disability beneficiaries cannot understand or read the instructions provided by the agency or are physically or mentally unable to comply with them. SSA has an affirmative obligation to assure accommodation to mental or physical impairments that could prevent voluntary compliance.

SSA must contact recipients scheduled for a continuing disability investigation (CDI) and determine whether they will need help in complying with instructions for the review. If help is required or if the person asks for assistance, SSA must provide it or refer the person to a local agency or organization which will assist the recipient.

Section 206: Accessibility and Reimbursement Requirements for Hearings

SSA has been insensitive to the difficulties disabled persons have in fully exercising their appeal rights. Often hearings are held where public transportation is difficult or costly. Hearings are sometimes in buildings with architectural barriers. SSA reimburses for travel only where the distance is over 70 miles. No provision is made for the cost of the special transportation often needed by the disabled person.

SSA must hold disability hearings at a location and in a building reasonably accessible to the disabled applicant. SSA must also reimburse an applicant who presents evidence of financial need (in advance if necessary) for expenses of obtaining and presenting medical evidence, travel costs, attendants and witnesses.

Section 207: Qualifications of DDS Medical Personnel

Many critical medical decisions used to determine an individual's disability are made by professionals untrained in the appropriate specialty. For example, internists have been used to evaluate whether a mentally ill individual can engage in competitive employment.

Decisions on medical eligibility benefits must be made only by appropriately qualified professionals. Determinations of mental impairment can only be made by a psychiatrist or psychologist.

Section 208: Regulatory Standards for Consultative Examinations

State disability determination agencies rely heavily on consultative examiners (CEs are physicians under contract to SSA to perform medical evaluations) in determining eligibility for disability benefits. Current problems involve poor quality of reports, referrals to CEs who are not qualified in the appropriate specialty, and the lack of monitoring of CEs.

SSA must issue detailed regulations setting forth (a) the standards to be used by state agencies and federal personnel to identify consultative examiners and refer individuals to them for medical examinations, and (b) mechanisms for monitoring the quality of CE referrals and reports.

Section 209: Payment for Consultative Examinations

Some states' rates for consultative examinations are so low, few physicians will perform thorough examinations. Raising the payment standard would increase the pool of physicians and improve the quality of the examinations.

Consultative examiners will be paid for their services at the Medicare Part B rate for comparable physician services.

Section 301: Uniform Standards

SSA uses the Program Operations Manual System (POMS), a set of unpublished and frequently changing memoranda, as its primary policy-making tool. But ALJs and courts rely on the law and published regulations. Decisionmaking criteria are thus inconsistent at different levels of review.

SSA disability programs are bound by Administrative Procedure Act requirements of public notice and comment prior to publication of a final rule. Moreover, only published rules promulgated pursuant to APA -- not informal policies -- will apply uniformly at all levels of decisonmaking.

Section 302: Compliance with Certain Court Orders

In recent years, SSA has "non-acquiesced" in decisions of circuit courts of appeals rather than appealing the decisions to the Supreme Court. In other words, SSA has failed to apply decisions with which it disagrees to anyone beyond the plaintiffs in a specific case.

SSA must apply rulings of circuit courts of appeals to all beneficiaries in the circuit or request review of the decision by the Supreme Court. If the Supreme Court does not accept review, circuit court rulings will apply in all states of the circuit until the Supreme Court rules.

Section 304: Continued Assistance for Potential Concurrent Beneficiaries

The Social Security Amendments of 1982 (PL 98-21) requires SSA to notify all elderly beneficiaries, who are potentially eligible, of the availability of SSI and to encourage them to contact their district offices. Many disabled persons who are not elderly may also need this.

SSA must inform all OASDI beneficiaries, who may be eligible, that assistance in applying for Supplemental Security Income is available upon request.

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Chairman PICKLE. We thank you, Mr. Manes. You have given us some good testimony. I notice that you have concentrated on H.R. 2987, and I am sure Mr. Shannon would be pleased to know that, but I assume he knows that anyway. And some of the things that you have mentioned—as you know, today these things have been discussed in some detail, so we are going to try to look at all your testimony and see what part we can incorporate.

We thank you, sir.

Now Mr. Dan Skoler, representing the American Bar Association. Would you proceed?

STATEMENT OF DANIEL SKOLER, COMMISSIONER OF THE AMERICAN BAR ASSOCIATION, COMMISSION ON LEGAL PROBLEMS OF THE ELDERLY

Mr. SKOLER. Mr. Chairman, the hour is late. Your attention span has been incredible, as has been that of your staff associates and the members of your committee who were here previously, and I shall be brief. Our American Bar Association Commission has submitted written testimony which I think speaks for itself, and we assume that it will appear in the record of the hearing.

Chairman PICKLE. It certainly will. Do you want to highlight it, sir?

Mr. SKOLER. I would like to do that by a brief page of summary comments. I would also like to draw attention to two corrections which should be made. On page 7, line 11 of our testimony, the word "unfavorably" should be changed to "favorably." Page 7, line 11.

Chairman PICKLE. "Unfavorably" should be changed to what?

Mr. SKOLER. "Favorably," on line 11. And then on that same page, on the fourth line from the bottom, and in fairness to the Social Security Administration, the phrase "It generally publishes" should read, "It has in some instances published."

And now I will offer some brief oral comments. Our commission wants to thank you for focusing your attention today on the current adjudicative process within the social security disability benefit program and we appreciate the opportunity to testify on this important topic, this incidentally being the first appearance of our commission before your subcommittee, Mr. Chairman.

Chairman PICKLE. Good.

Mr. SKOLER. I am a member of the American Bar Association's Commission on Legal Problems of the Elderly and I speak on its behalf and on behalf of the American Bar Association today. I also happen to serve as an official of the Federal Government in a department far removed from the social security program and just want to emphasize that the views expressed here today in no way reflect those of my Federal employer.

The Commission on Legal Problems of the Elderly is an interdisciplinary commission created in 1978 by the ABA's Board of Governors to analyze and respond to law-related needs of older Americans. We have focused on six priority areas, one of which is social security. The others involve long-term care for the elderly, age discrimination, simplification of the procedures and forms to which the elderly are subjected, legal services to the elderly and housing problems of the elderly.

I will now turn to a summary of our conclusions and recommendations and the issues that concern us here. The ABA Commission is deeply concerned about three issues regarding the adjudicative process within the social security disability insurance program. These have been discussed before, and our views by and large parallel those of the immediately preceding speakers.

The first concern pertains to observance by SSA of the notice and comment provisions of the Administrative Procedure Act when it revises, expands or elaborates on its disability standards. The commission believes that at least some of the SSA's directives have been more than interpretative rules or general statements of policy and that they should be issued after notice and comment rulemaking.

Our second concern involves SSA oversight of ALJ decisionmaking. The ABA in 1976 reaffirmed its commitment to the independence and impartiality of administrative law judges, urging Federal authorities to review disciplinary actions by any Federal agency which would have the purpose and effect of impeding such independence and impartiality.

The commission believes that one-sided review and correction under the SSA own motion program, that is review limited only to judges with the highest rates of reversal of agency benefit denials, while not itself a disciplinary action, can nevertheless jeopardize the independence of ALJ's and undermine public confidence in the integrity of administrative review. Accordingly, the commission applauds those steps taken by SSA to broaden the scope, representation and balance in "own motion" review.

I note that earlier today Deputy Commissioner Simmons added another phase when he indicated that the Social Security Administration was now reviewing the "high denial" judges for quality and accuracy, or at least those who had exhibited the most deficient records of quality and accuracy.

Chairman Pickle. I didn't catch that he had added that additional dimension. I am glad you pointed that out.

Mr. Skoler. The final issue is SSA's nonacquiescence in some decisions by Federal courts of appeal with which SSA disagrees under which the decision is neither followed in the circuit in which issued nor appealed to higher judicial authority. The commission is concerned not only that such practice ignores the basic legal principles of stare decisis and law of the circuit but as a result may well deprive claimants of the right to a determination based on that precedent.

Thank you for affording our commission this opportunity to comment on a topic of great concern to many Americans.

Chairman Pickle. Thank you. I would like to dwell on the last point for a minute. If I understand your statement, it is your concern that a court would make a decision, and regardless of their decision, that it would have no effect basically on the Social Security Administration with respect to their rulemaking, is that essentially what you are saying to me? I say "no effect," may or may not have an effect.

Mr. **Skoler**. The particular concern expressed here is somewhat different from the example Mr. Fried brought of totally ignoring the decision in the case in which it was issued. Our concern is that the principles of the law of the circuit require the Social Security Administration, faced with a Federal circuit court interpretation of the social security law to at least in that circuit follow that opinion unless it is actively appealing it or taking some comparable initiative in the manner of the Internal Revenue Service nonacquiescence policy that was described to you a few moments ago.

My personal view is that nonacquiescence is not an illegitimate step for an agency as large as SSA to take. The issue is whether the scope of that is such that it ignores the law of the circuit.

The established law of this Nation is that within a circuit a Federal court's interpretation of Federal law, Federal regulations, and interpretations thereof are binding upon Federal administrative agencies.

Chairman **Pickle**. At some level we have got to make a decision on the issue that is before a court. And when you use the term "nonacquiescence," do you mean at the local level, district level, or at the appeals level?

Mr. **Skoler**. Our concern is at the appeals level. It can be seen that it would be a great burden to adjust as complex and large volume a program as social security to the emerging law in every district court in the United States.

Chairman **Pickle**. Well, what do you do? We face the same problems here in the Congress. On occasion, the Internal Revenue Service, which issues a lot of regulations all the time, and we will issue a policy here and Internal Revenue will ignore it. And they have ignored it on occasions. Now, when we the Congress say this is the policy—right or wrong we say it—and Internal Revenue says they don't agree with it, usually we will call those gentlemen up here and we will have a little heart-to-heart talk with them.

Usually when there is a difference of interpretation, particularly in the legal area, somebody has to finally make a decision. When the question arises, whether it is with Congress and Internal Revenue, or SSA and the court system, usually that is a signal we must work out a different policy, or establish a policy for all to know. It seems to me there is a question whether it would be a good policy for the SSA to immediately say they have to change all their rules just because a court in California ruled to the contrary. That doesn't mean we have to change all the rules. But it is a signal there is a basic difference in the opinion of the courts and the Administration, and a coordination or a settlement of that issue has to be made.

I don't think we can either say we are going to be totally independent and ignore it, because we must work out the differences. Is that a fair approach?

Mr. **Skoler**. I think it is, Mr. Chairman. I am constantly impressed by the fact that the Social Security Administration deals in a volume of funds that exceeds the national budgets of all nations in the world except the United States and Russia. Thus, its problems are so complex that I would think this particular issue is deserving of some specialized congressional analysis and attention to provide the kind of fair ground rules you indicated.

Chairman **Pickle.** We must preserve the integrity of the court systems. We must keep the ALJ's independent. There will be differences of opinion within the court system and a rulemaking agency or an agency like SSA. We all must recognize that. We don't all think in lock step, but when we do have a disagreeement at the top level between the court and the agency, something has got to give. So I just say we have to set up—try to bring them back together again.

Thank you, sir. I appreciate your testimony. We have been staying with it long. So have you gentlemen. We thank you.

[The prepared statement follows:]

STATEMENT OF THE AMERICAN BAR ASSOCIATION, COMMISSION ON LEGAL PROBLEMS OF THE ELDERLY, PRESENTED BY DANIEL SKOLER, COMMISSIONER

Mr. Chairman, members of the Committee, my name is Daniel Skoler. I want to thank you for focusing your attention today on the current adjudicative process within the Social Security disability insurance program, and we appreciate the opportunity to testify on this important issue. I am a member of the American Bar Association's Commission on Legal Problems of the Elderly and am speaking on behalf of the American Bar Associaiton today. I also serve as an official of the federal government in a department far removed from the Social Security program and want to emphasize that the views expressed here today in no way reflect those of my federal employer.

The Commission on Legal Problems of the Elderly is an interdisciplinary commission created in 1978 by the ABA Board of Governors to analyze and respond to law-related needs of older Americans. The Commission has focused on six priority areas, one of which is Social Security. Two issues are of particular concern to the Commission regarding Social Security. The first is observance by the Social Security Administration (SSA) of the notice and comment rulemaking provisions of the Administrative Procedure Act (APA) when revising or expanding its disability standards. The second concern is the avoidance of pressure on Administrative Law Judges (ALJ's) to increase denials of claimants' appeals in administration of SSA's vigorous "own motion" review program of the quality and accuracy of ALJ decisions.

I. OBSERVANCE OF THE RULEMAKING PROVISIONS OF THE APA

By now many Americans are aware of the increased reviews of Social Security Disability Insurance cases mandated by the Disability Amendments of 1980 (42 U.S.C. § 421(i)) which the SSA began early in March, 1981. To date, the cases of hundreds of thousands of beneficiaries have been reviewed resulting in a termination rate, as reported at hearings last April conducted by the Senate Committee on Aging, of approximately 40 percent, nearly twice the number expected by the U.S. General Accounting Office study.[1] Of the 50 percent of the terminated beneficiaries who appealed the SSA determination that they were no longer disabled, ⅔ have had their benefits reinstated on appeal.[2]

While the Commission is deeply concerned about the effect these terminations have had and will have on disabled beneficiaries of mature age, some of whom may have no one to advocate their cause, the Commission is also interested in how this contraction of the Social Security rolls has been implemented. There has been concern that the Social Security Administration has been tightening and revising its disability benefit standards through Social Security Rulings and internal policy and manual issuances which are not promulgated as regulations subject to "notice and comment" rulemaking under the Administrative Procedure Act (APA). SSA's action in this regard has been undertaken as an asserted exception to the rulemaking requirements of 5 U.S.C. § 553.

In early 1980, for example, SSA developed a new policy regarding eligibility for mentally disabled claimants. SSA determined that a mentally impaired individual who does not meet a listed impairment—one so severe that its presence alone, without further evidence of inability to work, justifies a finding of disability—and who is 18–49 years old, is presumed to retain sufficient residual functional capacity to do at least unskilled work. This policy was clearly contrary to the regulations[3] and yet was never published for notice and comment rulemaking in the Federal Register. It was reflected only in official memoranda issued by SSA to certain state agencies—and not to the general public—which administer the disability program for SSA in their respective states.

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[1] U.S. General Accounting Office, Statement of Peter J. McGough, Associate Director, Human Resources Division, before the Special Committee on Aging, U.S. Senate, Apr. 7, 1983.

[2] Subcommittee on Social Security of the Committee on Ways and Means, U.S. House of Representatives, Social Security Continuing Disability Investigation Program: Background and Legislative Issue Paper, 98-3720, as derived from a GAO study.

Section 553(a)(2) of the APA exempts from APA notice and comment requirements matters relating to "benefits." In 1971, however, the Secretary of the then Department of HEW promulgated a rule waiving this exemption (36 F.R. 2532, Feb. 5, 1971). At the Annual Meeting in 1972, the American Bar Association House of Delegates approved a resolution, as recommended by the Section of Public Contract Law, which endorses Congressional legislation "to eliminate the current exemption from the rulemaking provisions of the Administrative Procedure Act on matters relating to public property, loans, grants *benefits,* or contracts" (emphasis supplied). Thus, while we support the secretary's waiver, the ABA also has urged Congress to make permanent this recommended change in the APA.

Although the Department of Health and Human Services in June 1982, issued a proposed rule partially withdrawing the waiver (47 F.R. 26861), no final rule has been issued, possibly due to the large number of comments in opposition to the proposed withdrawal. Therefore, notice and comment requirements continue to apply to the RSDHI and SSI programs.

Section 553(b)(A) exempts interpretive rules and general statements of policy from notice and comment requirements. Federal courts, however, have determined that if the policy has a "substantial impact," i.e., a substantive impact, on the rights and duties of persons involved in the program, notice and comment procedures apply.[4] The Commission is of the opinion that the Department of Health and Human Services' activity of implementing and tightening policy which has substantively affected the rights of Social Security Disability Insurance beneficiaries, particularly those with mental impairments, has been an activity which, because of its substantial impact, should first proceed through the notice and comment requirements rather than through unilateral agency action.

In addition, in a laudable effort to create greater consistency in interpretation and application of disability benefits statutes and standards which are binding on all SSA personnel, from initial claims adjudicators through the administrative law judges, SSA has over the past year and a half issued more than thirty interpretive and instructional directives as Program Policy Statements or Social Security Rulings, or both. None of these were subjected to notice and comment rulemaking requirements. We believe, however, that at least some of these may have been more than mere "interpretive rules" or "general statements of policy" within the meaning of the APA exception for such agency issuances [5 U.S.C. sec. 553(b)(a)] and, in fact, constituted de facto revisions or expansions of the detailed disability regulations that now exist.[5] As such, they should have been issued after notice and comment rulemaking; although, as we understand, not one was considered by SSA as including any provision or concept of sufficient substantive import to be viewed as a regulatory change.

Even if the foregoing SSA position were technically correct, in dealing with the sensitive and complex area of disability standards and determination, the Commission thinks that the preferable public policy is to provide notice and an opportunity to comment.[6] This public exposure in seeking to produce a different or more stringent cast to existing regulations and statutes which may not have been interpreted in quite the same way before can only help to assure compliance with the SSA mandate. SSA's disability standardization program over the past year and a half has been an intensive effort to "tighten" the disability standards and regulations, and it seems somewhat surprising that none of the changes, redefinitions and elaborations were viewed as rising to the level of a new substantive issuance warranting notice and comment rulemaking review. Indeed, it is our understanding that there have been no significant changes whatever in DHHS regulations on how disability is determined and by what criteria (37 C.F.R. Supart P) throughout all this activity.

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[3] GAO study, *supra* at Note 1, citing *Minnesota Mental Health Association* v. *Schweiker,* 554 F. Supp. 156 (D. Minn. 1982)

[4] *Burroughs Wellcome Co. Schweiker,* 649 F. 2d, 221 (4th Cir. 1981), *Reymolds Metals Co.* v. *Rumsfeld,* 564 F. 2d 663 (4th Cir. 1977).

[5] We do not believe the procedure is acceptable whether the change helps or harms beneficiaries. For example, Revenue Ruling 82–55, issued last October, provides that in determining whether a person has the capacity to engage in substantial gainful activity, "when a non-severe impairment is imposed on a severe impairment, the combined effect of all impairments *must be considered.*" Nevertheless, pre-existing Regulation 404.1522 in 20 C.F.R., Subpart P ("Determining Disability and Blindness") seems to clearly require that in determining capacity for substantial gainful activity SSA "will consider the combined effects of unrelated impairments *only if all are severe*" (emphasis added)

[6] The Commission notes H.R. 2987, now before this committee, provides for such notice and comment rulemaking (see Sec. 301).

II. PRESERVING THE INDEPENDENCE OF ADMINISTRATIVE LAW JUDGES

The second area of concern to the ABA Commission is that involving Social Security Administration oversight of ALJ decisionmaking. Since 1982, the SSA has been conducting an intensive review of the decisions of those Administrative Law Judges (ALJ's) whose determinations reflect a disproportionately high number of allowances of benefits to claimants who previously have been denied benefits or who have had their benefits terminated by the agency. These ALJ's are known as "high reversal" judges since they reverse agency denial decisions at a high rate. Under the APA, the decisions of ALJ's are in effect recommended decisions on behalf of the agency Secretary; the Secretary may legitimately exercise his/her "own motion" authority to review ALJ decisions as to benefit entitlement and to "correct" them if deemed erroneous.

The problem with SSA's review program, at least initially, was that it singled out only the "high reversal" ALJ's, subjecting some to "counselling", while the ALJ's with "high affirmance" rates were not reviewed in the "own motion," "Bellmon review," program. That practice, if continued indefinitely and although admittedly not of a disciplinary character, could have led to a conflict of interest wherein the judge developed an interest in the outcome of the case he or she was deciding. That is, the more often the ALJ decides adversely to the claimant (i.e., by denying benefits), the less SSA, a party to the action, will single out the ALJ and scrutinize his/her decisions. The result, we believe, is a "chilling", perhaps gentle for some and not so gentle for others, of the adjudicator's sense of independent judicial function.

In this regard, we were pleased that in early 1982, SSA extended its "own motion" review for erroneous reversal decisions of ALJ's to encompass a substantial random sample of the allowance decisions of all ALJ's and the decisions of newly-hired ALJ's. (The latter would be a likely error-prone group worthy of oversight as they honed their ALJ skills in the disability area.) We also commend and support the explorations at SSA's Office of Hearings and Appeals, as indicated in recent testimony of Associate Commissioner Hays, looking toward extension of "own motion" review to all error-prone ALJ's in SSA's mammoth corps (constituting three times as many ALJ's as in all other federal agencies combined) whether they be "high", "low" or "medium" reversers or affirmers. The Commission and the ABA are not unmindful of the many thousands of ALJ decisions affirming denials of benefits below which get reviewed by SSA in the normal appeals process available to dissatisfied claimants or terminated beneficiaries (i.e., appeal to SSA's Appeals Council), nor are we unmindful of the Congressional concern and mandate that led to the "own motion" review program. Our concern here is simply with possible unintended and undesirable effects of that effort.

The Association of Administrative Law Judges, Inc. has sued the Secretary of HHS, claiming imposition of illegal case production quotas and pressures toward deciding more cases adversely to claimants and favorably to the agency. The Commission avoids any comment on this, focusing its testimony instead on an expression of concern with undesirable effects of one-sided review and correction under the SSA "own motion" program of only those decisions unfavorable to the agency. However, the American Bar Association is on record as to its commitment to the absolute decisional independence of ALJ's and, by implication, the inconsistency of rigid quotas as to case volume or case outcome with that goal.

III. A COMMENT ON NONACQUIESCENCE

I would like to conclude with a brief word on the issue of SSA's nonacquiescence policy with respect to federal circuit court decisions on disability. When SSA receives an adverse ruling and disagrees with the outcome, it has in some instances published a Social Security Ruling "non-acquiescing" to the decision rather than appealing it. The decision is subsequently implemented only for the named plaintiff and is not followed by SSA even within the same circuit. The Association has no explicit policy on nonacquiescence by federal agencies in the statutory and regulatory interpretations of federal appellate courts. However, we are fully committed to the rule of law in judicial and administrative proceedings. We are impressed with the argument that in requiring its initial adjudicators and administrative law judges to ignore the "law of the circuit" in determinations and hearings when there has been a non-acquiescence ruling on the question under consideration, SSA may well be depriving claimants within the particular circuit of their right to a determination based on applicable law and precedent. The Commission believes that the "law of the circuit" is indeed binding on federal agencies[7] and SSA practice of non-acquiescence within a circuit itself, in the absence of a pending appeal from the circuit court ruling or similar initiative, may not be warranted and at the least is burdensome both to the government and claimants.

Chairman **Pickle**. Now, Dr. Floyd Davis, professor of neurology. It is fitting now that you be the last one to testify here today.

STATEMENT OF FLOYD A. DAVIS, M.D., PROFESSOR OF NEUROLOGY AND DIRECTOR, MULTIPLE SCLEROSIS CENTER, RUSH-PRESBYTERIAN-ST. LUKE'S MEDICAL CENTER ON BEHALF OF THE NATIONAL MULTIPLE SCLEROSIS SOCIETY

Dr. **Davis**. Mr. Chairman, it is a pleasure to be here, whether it be first or last.

I am a physician and I specialize in the field of neurology. I am a professor of neurology at the Rush Medical School in Chicago. I also direct the Multiple Sclerosis Research Center at the Rush-Presbyterian-St. Luke's Medical Center in Chicago.

I am testifying on behalf of the National Multiple Sclerosis Society and I serve on its medical advisory board. If you don't have our complete testimony, I have a copy here.

Chairman **Pickle**. I do have your statement. It will be included in the record.

Dr. **Davis**. I would like to review some of the highlights at this time.

The National Multiple Sclerosis Society through its medical advisory board has been working with the Social Security Administration for about 3 years now and working regarding the current SSA criteria for establishing disability in patients with multiple sclerosis. It is the view of those of us specializing in neurology and multiple sclerosis that the disability criteria used by the Social Security Administration are too narrow and do not reflect current medical opinion relative to the disabling nature of multiple sclerosis.

The effect of this narrow medical approach is that substantial numbers of persons with disabling multiple sclerosis are initially denied disability insurance coverage and the medicare coverage that accompanies it. By far the largest number of complaints our national office receives about disability determinations relates to the medical definition of multiple sclerosis and its failure to properly recognize weakness and fatigue.

Let me explain the nature of the problem and I will try to be very brief.

First of all, multiple sclerosis is a disease of the central nervous system that affects young people, usually between the ages of 20 and 40 and most of these people therefore have a work history. There are approximately 250,000 people in this country with the disease, and we have approximately 8,000 new cases every year.

Now, there is a lot I could tell you about the disease. What I want to focus on is what happens here to the neurologic tissue which relates to the problem at hand here. Normal nerve fibers are covered by a fatty material called myelin. It is like an electrical insulator. It permits impulse conduction to occur normally. In this disease that myelin or fatty covering is stripped away, thinned out, and as a result of that, there are abnormalities in impulse conduction in the central nervous system.

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[7] *Ithaca College* v. *N.L.R.B.*, 623 F. 2d 224 (2d Cir. 1980), *Allegheny General Hospital* v. *N.L.R.B.*, 608 F. 2d 965 (3rd Cir. 1979).

As a direct consequence of that, patients have signs and symptoms.

Now, there is a spectrum of abnormalities of conduction.

The mildest change we see is a slowing of conduction. The impulses work, but they go slowly down the nerve. That problem does not lead to a disabling problem for patients with multiple sclerosis. If they have that and that alone, they do fine usually.

The worst thing that happens to the nerve is that it won't conduct at all, and when the nerve doesn't conduct, that leads to big problems, like paralysis, where a person cannot use an arm or a leg.

Now, the Social Security Administration recognizes paralysis. In essence, they are recognizing block of conduction. I want to direct your attention to a problem of conduction which rests between slowing and total block.

There are many nerve fibers in many patients which we know experimentally are not blocked, they do carry nerve impulses, but they block within a short period of time after beginning to carry these impulses. That is, the nerves themselves fatigue.

This problem leads to some problems in the patient. And the problems in the patient we call motor and sensory fatigue. And I can demonstrate these here for you. But first let me just make it clear that it is this problem, motor and sensory fatigue, which is not recognized by the Social Security Administration.

Now, if I were to open and close my hand here rapidly, even at the end of the day I can do that. A patient with multiple sclerosis who has this middle disability in the nerve fiber will get the first few out very well, and then it will slow, and then it will become absent or nearly absent. If the individual then rests the hand for a few seconds or minutes, he can go again. That is motor fatigue.

Those patients who have a problem with the nerve behind the eye, the optic nerve, they can look at material and read it, but as they are reading, begin to fade and lose the print they are looking at. They have to then close their eyes and look away and then they regain it. They have sensory fatigue.

These two problems are not recognized by SSA. Are they disabling? You bet they are.

This motor and sensory fatigue can occur in patients with multiple sclerosis who appear on the surface to have minimal or even no apparent disability. The phenomenon is now recognized as characteristic of the illness and often represents a major disabling symptom.

It is in effect uniquely associated with multiple sclerosis. It is not, I repeat, it is not a mentally or emotionally based symptom. It is physical. It is in fact phenomenologically identical to fatigue which is seen in another neurologic disease called myasthenia gravis which is recognized by SSA as a major disability for that disease.

Now, what can happen to a patient with multiple sclerosis whose major disability relates to sensory and motor fatigue?

Well, generally there is a determination made by those assessing disability that the person does not fit the definition in the medical listings, and is therefore not severely impaired. This medical judgment results in an adverse determination. The crucial and the compassionate question of work history, education, and vocational capacity are never even reached.

For nearly 3 years now the National Multiple Sclerosis Society has been engaged in discussions with the Social Security Administration about this issue. We have had no problems talking to the Social Security Administration. After discussions with the Social Security Administration, and meetings in April of 1982, we submitted in November of 1982 suggested changes in the definition of multiple sclerosis and papers in support of our propositions. The materials we developed resulted from work done by our entire medical advisory board, consisting of 50 physicians and scientists.

You should have a list provided of that board.

We have had no official response to our analysis or material. We have never had a specific written analysis of our proposals or our medical facts and opinions.

While SSA may yet change its definition of multiple sclerosis, and we hope they do, there appears to us to be a serious flaw in the process. Shouldn't there be an organized system for presentations of data to an SSA medical advisory panel which is obligated to review, to assess and to respond? In our particular case, we believe that the weight of opinion of the nation's medical experts in multiple sclerosis clearly supports a new definition of multiple sclerosis which reflects the motor and sensory fatigue factor.

The phenomenon is physical and physicians can objectively observe it. We know enough about the disease to know what is physically causing this disabling condition. In many cases it is severely disabling and makes sustained work of any kind impossible. These are not cases of lazy people who are "dogging it." They are physically ill individuals experiencing serious effects of this disease. The adverse disability determination either often causes these people serious emotional or mental problems for they are characterized as malingerers who do not have a serious impairment, when in fact, they do.

We hope this subcommittee will express its concern to the Social Security Administration about this specific problem and assist us in solving it.

Thank you, sir.

[The prepared statement follows:]

STATEMENT OF THE NATIONAL MULTIPLE SCLEROSIS SOCIETY PRESENTED BY FLOYD A. DAVIS, M.D., DIRECTOR, MULTIPLE SCLEROSIS CENTER, RUSH-PRESBYTERIAN-ST. LUKE'S MEDICAL CENTER AND PROFESSOR OF NEUROLOGY AT RUSH MEDICAL SCHOOL, CHICAGO, ILL.

OUTLINE OF TESTIMONY

1. The issue discussed is the process of establishing medical policies for disability programs.
2. SSA does not appropriately determine disability for those with multiple sclerosis.

3. The problem is the failure of the medical listings and related policies to recognize multiple sclerosis with motor and sensory fatigue as a disabling condition or severe impairment permitting assessment of vocational capacity.

4. The SSA process for developing medical policies and standards and changes in them is generally inadequate and has not been responsive in the case of MS.

5. The SSA should have a Medical Advisory Committee of non-governmental experts to advise it on medical policies and changes in medical policies and to hold hearings and take evidence from the interested parties.

6. (For the record only.) The NMSS generally endorses the provisions of H.R. 2987, particularly those dealing with multiple impairments and required job evaluation for those with neurological and mental impairments.

7. (For the record only.) The NMSS also proposes that current Medicare policy regarding denials for motorized vehicles similar to wheelchairs be revised since it discourages independence for the severely disabled.

Mr. Chairman, my name is Floyd A. David. I am a physician and specialize in the field of Neurology and Multiple Sclerosis. I am a Professor of Medicine at Rush Medical School and Director fo the Multiple Sclerosis Center at Rush-Presbyterian-St. Luke's Medical Center in Chicago. I am testifying on behalf of the National Multiple Sclerosis Society and serve on its Medical Advisory Board and Executive Committee.

The National Multiple Sclerosis Society, through its Medical Advisory Board, has been working with the Social Security Administration for about three years regarding the current Social Security Administration criteria for establishing disability for those with MS. It is the view of those of us specializing in neurology and multiple sclerosis that the disability criteria used by the Social Security Administration (SSA) is too narrow and does not reflect current medical judgment relative to the disabling nature of multiple sclerosis accompanied by motor and sensory fatigue. The current limited medical description is tht substantial numbers of persons with disabling multiple sclerosis, are initially denied Disability Insurance coverage and the Medicare coverage that accompanies it. We do not have specific numbers of cases that fall into this category, but by far the largest number of complaints our National Office receives about disability determinations is in the medical definition of multiple sclerosis (MS) and its failure to properly recognize motor and sensory fatigue.

My testimony today relates generally to the point of the appropriateness of standards and policies used by Social Security for determining disability, particularly standards and policies that involve medical determinations. The issue involved is whether these standards, policies and definitions adequately reflect current medical opinion and practice and, if not, how such current practice and opinion can impact upon the SSA system.

Multiple sclerosis is a case in point regarding the medical criteria used by the agency and the process by which these criteria are established. My testimony also raises the more specific question of when MS should be determined to be disabling from a medical standpoint.

BACKGROUND DATA AND INFORMATION

Multiple sclerosis has been recorded to affect some 130,000 Americans and we believe this figure may be upward of 250,000. The annual incidence of MS is estimated at about 8,000 or about 4.2 persons per hundred thousand (Citation: Baum and Rothschild, "Incidence and Prevalence of MS," Annals of Neurology, Vol. 10, No. 5, November 1981, page 420). It is not among the most prevalent disabilities, therefore, but its effects are severe. It is a disease which generally affects those between 20 and 40, (*Ibid.*). The disease affects more females than males by a ratio of 1.7 to 1 (*Ibid.*). Interestingly, the prevalence of MS is much higher in regions above the 37th parallel than in those below it (*Ibid.*). Because the disease is most prevalent among those 20 to 40, most persons with MS have had a work history, and are eligible for Social Security Disability Insurance. The disease is life-long in duration.

MS is a disease of the Central Nervous System (CNS), acquired in youth. The first clinical symptoms and signs usually appear after a dormant, symptom-free interval of five years or more. The most characteristic pathological feature of multiple sclerosis is patchy areas of inflammation and destruction of myelin, the material which forms an insulating sheath around nerve fibers, followed by scarring scattered throughout the white matter of the brain and spinal cord. There is a wide range of severity involved. Acute MS is severe and progressive, often leading to death in months. Benign MS is mild, seldom recognized, compatible with normal life expectancy and may not be disabling. The great majority of cases lie between these extremes, with the most frequent cases experiencing intermittent periods of symptoms and signs (exacerbation) followed by a period of improvement (remission). A smaller number of cases, usually of relative late onset, have slow, steady progression with spastic paraparesis as the most common manifestation.

Exacerbations occur in nearly all cases and vary in frequency, duration, character and severity and commonly show evidence of more than one area of the CNS involved. Remissions similarly vary in duration and in the extent of improvement. With time, a pattern of the clinical course is sometimes established but generally the course is not predictable in individual cases. The degree of improvement diminishes after each bout of symptoms, in most cases producing a downhill course. A majority of cases develop significant, permanent disability and impairment of neurological functions within five to ten years after the first period of symptoms.

The symptoms and signs of MS may involve vision, balance, coordination, muscle power, sexual function and bladder and rectal functions. In a minority of cases, impairment of memory and intellect may occur. The symptom of fatigue with reduction of stamina is almost universal and frequently is, in itself, incapacitating.

The diagnosis of MS is based on clinical judgment. Laboratory tests, including CSF gamma globulin determinations, evoked potentials and CAT scanning are helpful adjuncts but are not specific.

THE DISABILITY DETERMINATION PROBLEM

The major problem in the disability determination process for those with MS involves initial determinations of eligibility and the physical phenomenon of fatigue. The medical definition of MS in the SSA guidelines, referred to as medical listings, limits MS narrowly and does not include the condition of motor and sensory fatigue. (The motor system is that involving movement.)

As noted earlier in the testimony, MS is a disease in which the fatty covering of nerve fibers is destroyed. This is referred to as demyelination. This demyelination leads to short circuiting which slows or blocks the passage of nerve impulses. This results in paralysis and spasticity. These aspects of the disease are covered in the medical listing definition. Demyelination may also result in substantial physical fatigue caused by a failure of the nerves to faithfully conduct the normal number of impulses. This fatigue is caused by the disease and will result in substantial reduction of motor function comparable to paralyses and paresis.

Fatigue is a universal complaint and phenomenon in patients with MS. It can involve both the motor and sensory systems and is characterized by a progressive loss of function which, in most patients, recovers with relatively short rest periods. In the motor system, it can affect the ability to perform rapid, alternating movements of the hands and is particularly noticeable with attempts at ambulation. In the visual system, patients can develop a fatiguing of vision whereby the vision actually blurs or becomes nonexistent for varying periods of time. As mentioned previously, all of these phenomena, while reversing on rest, recur with persistent activity. The degree of activity necessary to produce the fatigue phenomenon can be mild to moderate in nature. It can be shown that with continued stimulation of demyelinated nerve fibers, there is a progressive decline in the ability of the fiber to conduct trains of impulses.

Many patients who demonstrate the fatiguing phenomenon are seriously disabled. They often show other evidences of inability to function such as a reversible severe worsening of motor and sensory functions with small increases in body temperature unassociated with fatigue. These individuals have large numbers of nerve fibers which are in a state of borderline function and which suddenly turn off when the body temperature is only elevated one or two degrees. It is believed that these borderline functioning fibers are probably also the same population of fibers which are responsible for the fatiguing phenomenon also described above. Thus, in a sense, many patients with MS appear like the tip of the iceberg. Often, what is seen on simple inspection represents only a small part of the overall difficulty that the patient is able or likely to experience under usual working or even simple activities of personal hygiene.

In summary, then, fatigue can occur in patients with MS who appear on the surface to have minimal or even no apparent disability. The phenomenon is now recognized as characteristic of the illness and often represents a major disabling symptom. It is an effect uniquely associated with MS. It is not a mental or emotional disorder. As a physical phenomenon, it is identical to fatigue in myasthenia gravis, recognized by SSA as a major disability.

The current medical listing definition of MS is essentially as follows, and the 1982 proposed revisions continue this definition:

"Multiple sclerosis with either:

(a) Significant and persistent disorganization of motor function (paresis, paralysis, tremor or other involuntary movements) resulting in sustained disturbance of movement or gant and station; or

(b) Visual or mental impairments (chronic brain syndrome)."

Many persons with disabling MS do not have the characteristics of either (a) or (b). They are not paralyzed nor are they visually or mentally impaired. However, they are disabled from the physical phenomenon I have referred to as motor and sensory fatigue. It is related directly to the disease which often renders them unable to work as if they were paralyzed or had the other facets of MS that are recognized in the medical listings.

In these cases, there generally is a determination made by those assuming disability that the person does not fit the definition in the medical listings and is not severely impaired. This medical judgment results in an adverse determination. The critical and compassionate questions of work history, education and vocational capacity are never reached.

THE PROCESS OF CHANGE IN THE SOCIAL SECURITY STANDARDS AND POLICIES

For three years now, the NMSS has been engaged in discussions with the Social Security Administration about the SSA criteria for MS. Dr. Blumenfeld, the Medical Director of SSA, has been personally involved and very cooperative, but there has been no official response or criticism from SSA. After discussions with SSA we submitted, in November of 1982, suggested changes in the definition of MS and papers in support of our propositions. The materials we developed resulted from work done by our entire Medical Advisory Board consisting of over 50 physicians and scientists. A list is submitted for the record. Our Medical Advisory Board also met with SSA personnel in May of 1982. On April 5, 1983, we submitted to SSA more material developed by our Medical Advisory Board. We have had no official response to our analysis or material. We have never had a specific written analysis of our proposals or our medical facts and assumptions. There is also no Committee of Medical Experts used to review medical matters such as we have raised. Such Committees are commonly used by the Food and Drug Administration and the NIH to review medical evidence and literature.

While SSA may yet change its definition of MS, and we hope it does, there appears to us to be a serious flaw in the process. Shouldn't there be an organized system for presentations of data and medical opinion by SSA and a medical advisory panel which is obligated to review and assess and respond to the applicants. We specifically recommend that SSA establish a Medical Advisory Committee of experts from various specialties to advise the agency as to changes in medical policies and to hold hearings and take testimony from the public.

In our particular case, we believe that the weight of opinion of the nation's medical experts in MS clearly supports a new definition of MS which reflects the motor and sensory fatigue factor. The phenomenon is physical and physicians can objectively observe it. We know enough about the disease to understand what is physically causing this disabling condition. In many cases, it is severely disabling and makes sustained work of any kind impossible. These are not cases of lazy people who are "dogging it." They are physically ill individuals experiencing serious effects of this disease. The adverse disability determination itself often causes these people serious emotional and mental problems for they are characterized as malingerers who do not have a serious impairment, when, in fact, they do.

We hope this Subcommittee will express its concern to the Social Security administration about this specific problem and assist us in solving it. We also hope that this Subcommittee will seriously consider reforms of the process by which medical criteria and policies are established and current medical data and opinion received and reviewed.

To summarize:

(1) Disabled MS patients are not being assessed appropriately under the current disability determination system.

(2) The narrowness of medical listing criteria relative to MS is largely the cause of this problem in that motor and sensory fatigue resulting from a failure of impulse conduction is not recognized by the listings.

(3) The system of establishing medical standards and policies is not effective in dealing with changing medical opinion and data.

We are attaching to our testimony for the record a brief supportive statement about H.R. 2987 and specific provisions in it. The statement includes a matter related to Medicare for the disabled as well.

H.R. 2987

We would like to comment briefly on H.R. 2987, introduced by Congressman Shannon. We are supportive of H.R. 2987, and its reforms of the disability determination law.

Of particular interest to us is the provision which permits SSA to consider the cumulative and combined effects of multiple impairments in making disability determinations. A person with MS may have vision, memory, locomotion, bladder control and other problems, the cumulative effect of which may be disabling despite the fact that no one problem would result in a determination of disability. Also of particular interest are the provisions raising the standard of review which SSA must use in proceedings for the termination of benefits and establishing more specific standards relative to work evaluation prior to initial disability determinations. Like many of the issues related to mental health impairments, persons with MS are never evaluated specifically for their employment capacity but are denied eligibility because the impairment does not meet the medical listing definition. The requirement of H.R. 2487 that neurological impairments as well as psychiatric ones be referred to a work evaluation source is one adequate remedy for some of these cases. As noted earlier in our testimony, individuals with MS experiencing severe weakness and fatigue but not meeting the two-pronged definition of MS in the medical listings are customarily found to be ineligible because they do not, as a medical matter, have a severe enough impairment. No job evaluation evidence by vocational experts is even considered for the ALJ's have determined that job evaluation is irrelevant in these cases. The "ability to work" provision of H.R. 2987 would enable such evidence to be considered and permit a more thorough and reasonable assessment of the existence of disability in such cases. The present system is far too arbitrary with respect to these MS cases.

MEDICARE FOR THE DISABLED—MEDICAL EQUIPMENT

For those disabled people who cannot work and are receiving Disability Insurance, self care and independent function are of critical importance both to the individual and to the public programs which assist them. If independence is not encouraged, institutional care may result with the increased costs that usually are attendant to such care. Where independence is encouraged, the individual is likely to be much more productive, needing less assistance and possibly working on at least a limited basis. For individuals who are paralyzed or otherwise have lost the use of their legs, wheelchairs or similar vehicles are essential for locomotion. For individuals without the use of arms and legs, motorized vehicles are essential for mobility.

Recently, Medicare denied to a 54-year-old person with MS, coverage of a motorized vehicle referred to as a cycle chair. This case was reported in The Washington Post and Richmond Times Dispatch. The cycle chair was prescribed for him by two physicians who specialize in neurology rather than an ordinary motorized wheelchair to move about on his lawn and work in his rose garden. The cycle chair served all other necessary functions that a motorized wheelchair would serve to the individual according to his physicians. The cost of the equipment is a bit over $1,000, whereas a motorized wheelchair costs three times that amount. The decision seems silly from every possible perspective. The Administrative Law Judge involved indicated that he disagreed with the result but was bound by a Medicare directive to its agents indicating that these cycle chairs could be used outside the home and for non-medical purposes such as golf and were, therefore, not to be covered.

Policies such as these discouraged independence and are not cost effective in the long run. This particular policy is not cost effective in the short run either. We believe that this vehicle is just the kind which Congress intended to cover when it passed the provision of Public Law 95-216 in 1977 including coverage of power operated vehicles serving the same or similar purposes as wheelchairs where such vehicles are determined by a physician to be medically necessary.

Chairman PICKLE. Well, I thank you, Doctor.

You have my attention when you talk about this subject. This has affected members of my family.

You don't contend that SSA does not count multiple sclerosis as a disability; they do, but they are slow to do it and are not handling it appropriately.

Dr. DAVIS. We are saying they are people severely disabled, and they are not even recognized, so they never get to first base, let alone second base.

Chairman PICKLE. You recommended that social security should have a medical advisory committee of nongovernmental experts to assist SSA in making determinations or setting guidelines and standards.

One of the proposals that this committee or the groups meeting and trying to advocate a bill, recommending the establishment of an advisory committee. It would be an advisory committee on a broader subject. But part of that committee would certainly be in the medical field. So if you were made a part of an advisory committee, you would at least have some input. And other organizations concerned and sincere about it would also have a choice and chance to have an input into it.

I am beginning to think maybe an advisory committee might be a helpful thing. None of us want to slow down the process. But it is also important to get input from various organizations.

So I think you make a good point in your recommendation. I am pleased to have it. Frankly, I feel better informed by hearing your testimony on multiple sclerosis.

Dr. DAVIS. Thank you. One other point. Our problem has not been making an input. Our problem has been in getting a response after the input.

Chairman PICKLE. You do have to get a response. They just have not heard you.

Dr. DAVIS. Perhaps.

Chairman PICKLE. It is late in the afternoon.

Well, I thank you very much for your testimony. I appreciate all your testimony. We will make each statement a part of the record, and we will read and examine them. And if you have additional statements or recommendations, we will be glad to have them. We suggest you get them into us now. If you have others who want to submit something for the record, ask them to get it in, because we want to move forward if we can. We are not going to try to write a bill that suits us. We are trying to get as many opinions together as we can and move forward.

We are not going to satisfy everybody. You may not be totally satisfied. But that would be true if we waited until the year 2000. And I haven't got that much time. So we will proceed as quickly as we can.

Again, I want to thank you very much for your testimony.

The committee stands adjourned.

[Whereupon, at 4:30 p.m., the hearing was adjourned.]

[Submission for the record follows:]

STATEMENT OF JOHN D. HARRIS, PRESIDENT, NATIONAL COUNCIL OF SSA FIELD OPERATIONS LOCALS, AFGE

Mr. Chairman, my name is John Harris. I am President of the National Council of Social Security Administration Field Operations Locals, which is affiliated with the American Federation of Government Employees (AFL-CIO). My organization is the labor union representing 35,000 Social Security workers in approximately 1,300 field offices in the nation, Puerto Rico and Pacific Islands.

Social Security workers have a unique viewpoint of the programs we administer. We hope that by our testimony we can share with you some of our daily experience in serving the nation's disabled and elderly. Within all the facts and figures that are used in the discussion of this or any other issue involving Social Security are human beings that we face and speak to in the offices where we work. These issues are never abstract to us. They have touched us personally.

Today we testify again about the problems of the disability program. These problems are not new. In fact, Mr. Chairman, they have pursued your committee relentlessly since the beginning of your tenure as its chief. We are aware how much effort and time has gone before on these problems, and we know there is perhaps nothing we can say which can better inform you about the nature and extent of the problems. So we are going to confine ourselves to a specific issue and a specific solution which we hope you and your committee will consider when you mark-up legislation in coming days.

It has been said—and there is some evidence to support it—that the current application of disability determinations is narrow, sometimes unfair, and motivated by a desire to cut the beneficiary rolls. It has also been said—and there is some evidence to support it too—that during the middle 1970's the application of disability determinations was poorly managed, disparate and varied between the state agencies, sometimes unsound, and threatening to the solvency of the disability trust funds. We believe in both of these statements, and we believe that the crisis which your committee undertook to resolve in 1980 with disability legislation is no greater nor lesser than that which you face now. It is ironic but it is not wrong that some of the proposals to solve the current disability problems seem to contradict what you did in 1980—for example, a moratorium on continuing disability investigations. Circumstances change; necessity requires flexibility in social programs. We support such a moratorium. But we are obliged to observe that the shifting perspectives on disability determinations tells of a great unnoticed issue: the Social Security Administration has yet to define disability in reliable terms, it does not have a good tool with which to fairly and accurately determine who should get benefits and who should not, and who should get other services and assistance and what those should be.

When we say this we do not merely criticize the subjectivity of some of the procedures (some of the subjectivity is unavoidable at any rate, and the Administration errs more often by trying to make objective something which is a matter of judgment and discretion and makes arbitrary determinations). We are not only critical of the failure to direct continuing disability investigations on those with medical conditions which were likely to improve because of medical advances. Nor only critical of poor resources, poor training, and processing delays. And the fact that Social Security did not revise its disability standards for 10 years and then acted in haste and under political pressure to make it harder to get benefits is not the only reason we say that the Social Security does not know what a disability is. The evidence that is inescapable for us and what bothers us most are those vast numbers who are being denied benefits every day by the Social Security Administration. Our common sense, our eyes, tell us something is not right.

If we assume that Social Security is applying the law correctly, we would conclude that those who are denied are able to work. But from what we see, this is not always so. Even assuming a margin of error and even allowing that Social Security benefits are not meant for everyone with a medical problem which limits his ability to work, we think the current application of the law is far off its written word. A study by Social Security in 1979 found that only one (1) in ten (10) who are denied disability benefits ever return to substantial gainful activity (SGA). That study also found a higher than normal mortality rate among those denied benefits. An earlier study completed in 1965 by private consultants (the so-called "Project 21") also found the same pattern, although not as severe. They found that about three (3) in ten (10) of denied applicants returned to work. They concluded in their report, as did Social Security in its 1979 study, that this fact was very disturbing and suggested that something was fundamentally wrong with the disability process.

A disability is not merely a medical or physical condition. Some are disabled by a condition that another can more fortunately overcome. Disability is also a social and economic condition. This is not opinion; that is how it is set forth by the law. For that reason what is disabling, how much and how long it is disabling, and what laws, benefits and programs should help those various disabling conditions is going to change with time. It will also change with medical advances and with our social maturity to treat the disabled as equals. It is a dynamic definition we are looking for. Disability determinations must be based on the real world answers to the questions of this person's and that person's ability to work. But the Social

Security Administration does not now and never has sought such answers to those questions. Their disability determinations are mere abstractions, arbitrary and crude; they are not based on scientific findings of what does or does not constitute a disability in its total medical, social and economic terms.

The abilities and the rights of Congress to dictate to the Executive Branch what it ought to do are limited—both by constitution, as we were reminded last week by the Supreme Court, and by the realities of complex federal government. You cannot expect to legislate regulations or manage government by oversight. Yet you must be assured that regulations and program management are faithful to your intent and are carried on in good faith, not crafted by immediate political impulses. To accomplish this the institutions of the federal government (the agencies and departments) must be structured within the Executive Branch to balance the interests of the Congress, the public which they serve, and the President who must manage them. In the long run there should be a reorganization of Social Security to ensure that disability determinations are established scientifically and professionally, free from administrative caprice or political influence. Hopefully that is an issue which the soon-to-be-appointed Panel for an Independent Agency can investigate. In the short run we urge you to amend current proposals for an Advisory Council on Disability to charter it with the immediate task to review and propose revision of disability determination procedures. Such proposals should be made simultaneously to the Secretary of the Department and to the Congress. The Secretary should be required to adopt, modify or expressly reject those proposals in writing within a reasonable time frame. Because of the extraordinary importance of this issue to so many Americans, we also ask that the Advisory Committee be required to hold public hearings about its proposals before they are finalized, preferably in the field as well as in Washington. Finally, we ask that the Advisory Committee be further instructed to consider what services and assistance may benefit the disabled, in addition to Title II and Title XVI benefits under the Act, and to recommend to the Congress and the President appropriate measures of law and administration.

What we propose here does not mitigate the need for other action to deal with urgent and immediate problems. We therefore support H.R. 2987, in agreement with our friends in Save Our Security, and believe that those changes in law are necessary to bring relief to those currently terminated from benefits unjustly.

We think you face two difficult tasks in this regard: one very urgent and immediate and one which is more general and far reaching which we have addressed today. We wish you well in your coming deliberations.

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